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Medicine in the Special Period: Treatment-Seeking Behaviours in Post-Soviet Cuba

By

Tracey Spack ©

A thesis submitted to the Faculty of Graduate Studies and Research in
partial fulfillment of the requirements for the degree of Doctor of
Philosophy

Department of Anthropology

Edmonton, Alberta

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Aug 8/01

Submitted to the Faculty of Graduate Studies and Research 2001

La veradera medicina no es la que cura, sino la que precave.
José Martí, 1892

Later we will realize many times how mistaken we were in concepts that were so familiar they became part of us and were an automatic part of our thinking. Often we need to change our concepts, not only the general concepts, the social or philosophical ones, but also sometimes our medical concepts.
Che Guevara, 1969 *On Revolutionary Medicine*

University of Alberta

Faculty of Graduate Studies and Research

The undersigned certify that they have read, and recommend to the Faculty of Graduate Studies and Research for acceptance, a thesis entitled *Medicine in the Special Period: Treatment-Seeking Behaviours in Post-Soviet Cuba* submitted by Tracey Lee Spack in partial fulfillment of the requirements for the degree of Doctor of Philosophy.

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Para Anna,
¡Muchisimas gracias para todo!
Siempre tu hermana

Abstract

This thesis is about the introduction of traditional and alternative health care practices into Cuba's official, government-supported health care system. More specifically, I ask to what degree and how have traditional and alternative treatments been integrated into the official health care system; and how has the relationship among biomedicine, traditional and alternative medicine been affected and directed by contemporary Cuban culture, politics, and economics at individual, local, national, and global levels.

Data collected for this thesis were accumulated over 12 months of fieldwork in Havana between September 1998 and February 2000. Research was conducted as a participant observer in a clinic; and through semi-structured and unstructured interviews with patients, doctors, policy makers, medical professors, and practitioners within the unregulated, unofficial health care sector.

This thesis develops an image of pluralistic health care in Cuba as I saw it. From this image a model of form, function, and meaning in pluralistic health care is developed. Within this model, levels of influence and constraining and innovative factors interact in a dynamic fashion to produce new experiences at the level of the individual. Macro-level factors are discussed, including Cuba's official policy on alternative and traditional medical practices, the international and national dialogues that create and negotiate boundaries within which health care is to be

practiced, and how changes in health care policy and practice continue to serve to maintain the political ideologies of the Cuban government. Micro-level factors such as the doctor-patient relationship, and local and individual experiences within the health care systems, are used to illustrate how explanatory models of illness direct and influence Cuban treatment-seeking behaviours.

This thesis also explores questions pertaining to the persistence and increased popularity in the unofficial health care sector despite the fact that much of its *materia medica* has been incorporated into the official sector. It is argued here that certain cultural ideals and historical influences affect the acceptance, rejection, or ambivalence toward the incorporation of traditional and alternative medical practices into a previously monopolistic system. This issue is contextualized within larger beliefs and experiences within the everyday lives of Cubans living in a changing Cuba.

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Introduction

Thesis Statement

This thesis is about the introduction of traditional and alternative[1] health care practices into Cuba's official, government-supported health care system. More specifically, I ask to what degree and how have traditional and alternative medicine[2] been integrated into the official health care system in Cuba; and how has the relationship among biomedicine, traditional, and alternative medicine been affected and directed by contemporary Cuban culture, politics, and economics at individual, local, national, and global levels. Data collected for this thesis were accumulated over 12 months of fieldwork conducted in Havana between September 1998 and July 1999, and a second trip between December 1999 and February 2000. Research was conducted as a participant observer in a clinic in the municipality of Alonjas;[3] and through semi-structured and unstructured interviews with patients, doctors, policy makers, medical professors, and practitioners within the unregulated, unofficial health care sector.

Why Cuba?

The first thing I am always asked in any discussion about my thesis

---

[1] A health care system can be both alternative and traditional. When I speak of a *traditional* health care system, what is meant is that the system is based within a specific culture, and at one time was or still is considered dominant within its country of origin - e.g., Ayurvedic medicine in India or acupuncture in China. Both of these practices are *alternative* when practiced elsewhere.

Is "Why Cuba?" My initial thought is usually "Why not Cuba?" Aside from the obvious advantage of spending a year conducting fieldwork in a warm and sunny country with beautiful beaches, friendly people, and great music, Cuba has long held a certain personal draw that I find difficult to articulate.

My first visit to Cuba was in the summer of 1993. I went with two friends for a vacation because it was the cheapest available flight at the time; but after spending a week in the aquamarine waters and the white sands of Veradero (a popular tourist destination west of Havana) and touring the historical sites of Old Havana, I returned to Canada with a tremendous desire to learn more about what I felt was a unique and fascinating place. I returned in the winter of 1995 for a conference on social justice issues in Havana. At this conference I met many Cubans and increased my knowledge about the history, politics, economy, and culture of the island. It was during this visit that I first heard Fidel Castro give one of his famous speeches; and even though his speech was long (about three and a half hours) and ran through the lunch hour, I found myself hanging on his every word. Even those who despise Fidel Castro and his policies in Cuba find it difficult to turn away from his passionate, charismatic, and eloquent stage presence. My fascination increased, and I leapt at two future opportunities to return.

---

[2] I use the word medicine loosely to refer more generally to material medica as well as treatments and therapies.

[3] The name of the municipality has been changed in order to provide anonymity.

It was during these two subsequent visits that I began to study various issues surrounding Cuba's health care system. During my third visit in July of 1995, I learned of Cuba's initiatives to introduce traditional and alternative health care into its official health care system. In August of 1997 I returned to Cuba for my fourth visit as a Canadian delegate of the Fourteenth World Festival of Youth and Students, to try to learn more about these recent changes in Cuban health care policy. It was during this time that I visited my first alternative and traditional health care clinic in Cuba; and saw patients receiving acupuncture, laser therapy, and homeopathy. The director of the clinic informed me that they also practice Tai Chi, Chi Gong, hypnotism, nutritional therapy, moxibustion, mud therapy, and massage therapy; and that the majority of prescriptions given were for homeopathic remedies, proper diet, *medicina verde*[4] (herbal medicines), and exercise. The clinic staff consists of a specialist in natural medicine, a masseuse, a homeopath, a family doctor (or general practitioner), a nutritionist, an acupuncturist, a psychologist, and a nurse. Charts describing the various acupuncture points and displays of numerous herbal medicines were posted throughout the clinic. I was particularly impressed when I was shown a room being used as a resource library for people wanting to learn more about available alternative and traditional treatments so that they might be better informed in deciding how they want to be treated.

---

[4] *Medicina verde* (green medicine) is a tradition that embodies the influence of the island's Spanish immigrants, African-Cubans that were originally brought to Cuba as slaves, and Chinese labourers. This form of health care was, until 1990, not accepted in Cuba's official health care system; but knowledge of herbal treatments survived over the years in the form of popular home remedies. These herbal remedies were not given official recognition until 1991.

There are now hundreds of such clinics offering a wide variety of traditional and alternative treatments; every province now has a provincial institute and every municipality has a research centre for the development of traditional medicine.[5] Upon returning to Canada, I was motivated to perform an exhaustive search of the available literature on Cuba's health care system; and found that while the implementation of new policies on traditional and alternative medical practices in Cuba's official health care system is mentioned in the existing literature (e.g., Kuntz, 1994; Hemmes, 1994), apart from popular news sources, documentation and analysis are entirely absent. I now had a topic for a Ph.D. dissertation.

Objectives

The objective of this dissertation is threefold: first, this thesis will demonstrate how individual experiences, interpretations, and beliefs are accounted for and incorporated into Cuba's new health care system; second, it will attempt to understand, classify, and determine the success[6], as perceived by healers and patients, of the new pluralistic system of various health care models in Cuba; and third, this thesis will formulate a workable theoretical model of pluralistic health care delivery and treatment-seeking behaviors that addresses the role of the individual, the state, and the global network of social policy.

---

[5] Personal communication with Leoncio Padron, Director of Traditional and Natural Medicine, MINSAP, February 22, 1999.

[6] I have not done an efficacy study, as to do so would be far outside the scope of this dissertation. Any statements about efficacy are based on individual reports.

A secondary objective is to address the following questions: How, within the period of a few years, could a country that once officially viewed alternative and traditional medical practices as 'backwards' and 'superstitious' (Pederson and Baruffati, 1989) accomplish what many other countries, including Canada, have been attempting to achieve for many years? Is it useful or possible to lump a variety of alternative and traditional health care systems under one umbrella philosophy of health and healing? What impact do the legalization and promotion of alternative and traditional health care systems have on the individual's perception of health and the treatment of illness and disease? How does the bureaucratization of alternative, and especially traditional, health care systems affect their actual practice (from the perspective of both the healer and the patient)? Are the various knowledge systems associated with each of the traditional and alternative health care systems being utilized, or is merely the *materia medica* being absorbed by the biomedical model of health care? Is it really possible, due to the hierarchical nature of the biomedical model of health and healing, to have a successful integration of biomedical, alternative, and traditional health care systems? Are these new policies being embraced out of economic necessity and/or imposed international policies, or is there a deeper cultural congruence with many of the philosophies and knowledge systems of the various traditional and alternative health care systems?

A World of Contradictions

It is impossible to read or write about Cuba without having to come to terms with that which makes Cuba such a controversial and contentious topic of conversation. Throughout my research for this thesis, I have read many books and articles written about different aspects of Cuban history, politics, economics, and culture. Unfortunately, the majority of these writings eventually revert to an uncritical, cursory portrayal of the Cuban political system (see Pérez- Stable, 1989 for a review of the issues affected by such controversial views). Pro-revolutionary sources generally portray Cuba with romantic images of revolutionary heroes fighting to keep their country free from exploitation, racism, and foreign imperialism - a classless society in which everyone's basic needs are met and all are able to achieve the educational level they desire. They speak of the Cuban people as content, progressive, and willing to defend socialism to their death (hence the popular slogan *socialismo o muerte*, socialism or death). Other sources would have you believe that the Cuban people are living under a reign of terror, forced to comply with the mandate of a communist dictatorship they do not support, a politically apathetic people wanting of western culture and democracy (hence the popular joke *socialismo es muerte*, socialism is death). Clearly

Cubans, like any other people, cannot be accurately spoken of as a homogeneous block; and yet the passionate, heartfelt arguments portrayed at both extremes make it difficult to think of Cubans as individuals and even more difficult to view the Cuban situation objectively (see Pérez-Stable, 1989). Throughout both my library research and my fieldwork in Cuba, I myself have often found it difficult to resist the pull between the two sides.

I recall an episode in the first few weeks of my fieldwork when I met a German tourist in Havana who told me that Cuba is a "wretched country" with "sad, miserable people" governed by "the devil himself." I was shocked that his perception was so drastically different from my own, and found myself arguing just as strongly a biased argument in the other direction. I finally left, dismissing him as being grossly deluded and misinformed. However, I have now come to realize that in Cuba it is easy to find support for either extreme view. If one is only in Cuba for a short period of time, it is easy to see only the bad or only the good and ignore the rest; but after spending some time in Cuba, one is faced with the more difficult task of balancing these views and trying to make sense of the multitude of contradictions inherent in modern-day Cuban society. Throughout my research I tried to see Cuba from the perspective of the Cubans I met and know. I have found their views, in a general sense, not to be as polarized as those of the Cuban exiles or the *extranjeros*.[7] It is my belief that Cubans living in Cuba are in the best position to see both the benefits and the costs that come with the system they are living under, as it is they who experience it everyday. I now see Cuba as a country with many good and bad features, and even more that fall somewhere in between. While I find it more difficult to convey my new-found contradictory views, I believe them to be better informed than my initial impressions; and I can only hope that they will do justice to those who have shared their beliefs, views, and lives with me.

---

[7] Meaning "stranger." This word is used in Cuba to refer to any non-Cuban person.

Organization

This thesis is divided into eight chapters. Following is an outline of each chapter.

In Chapter one, Cuba: A Social History, I give a brief history of the social, political, and economic history of Cuba. This chapter also describes the cultural and demographic background of the Cuban people.

In Chapter two, Theory and Methodology, I provide the details of the methodology I employed in my data collection; and outline the theoretical approach used to analyze the data I collected and present in chapters four, five, six, and seven.

In Chapter three, The Globalization of Health Care, I outline the various policy approaches taken toward medical pluralism; and how the globalization of health care policies constrains the implementation of a pluralistic health care system. The chapter includes a discussion on the dynamic relationship between culture change at the group level and individual models of culture; the political and economic power relations that exist within any society that directly affect which institutions will be allowed to develop and change; the effects (both constraining and innovative) of the current trend of globalization on local societies and cultures; and the relationship between social class, poverty, political infrastructure, and health. This chapter deals with the multitude of external factors affecting the form and shape of national health care systems within which all local health care systems are situated.

In Chapter four, Cuba's "Official" Views on Medical Pluralism, the development of the post-revolutionary health care system in Cuba is described, including the form that it takes today in light of the changes made to its delivery. Furthermore, Cuba's own official policy on alternative and traditional medical practices is described. This chapter also reviews the dominant images of world health as defined by Christopher Keane (1998); and situates Cuba's particular brand of medical pluralism within these images through an analysis of recent health care policy in Cuba, as well as interviews conducted with Ministry of Public Health (MINSAP)[8] workers and medical professors.

In Chapter five, Negotiating Meaning in the Clinical Encounter, reactions to and attitudes of Cuban doctors and patients toward traditional and alternative medical practices within the official system are described, using examples from my interviews and observations in order to illustrate how these changes are interpreted, lived, and experienced by both doctors and patients. This chapter also describes the unique character of the doctor- patient relationship in Cuba; and how this affects, directs, and facilitates the incorporation of alternative and traditional medical practices.

In Chapter six, Treatment-Seeking Behaviors Outside the "Official" System, I explore the unofficial health care sector; and address questions pertaining to the reasons for its persistence and increased popularity in spite of the fact that much of its *materia medica* has been incorporated into the official health care system. This chapter addresses the unique character and idiosyncratic nature of the Cuban patient; and argues that certain cultural ideals and historical influences can influence the acceptance, rejection, or ambivalence toward the incorporation of traditional and alternative medical practices into a previously monopolistic official system. This issue is contextualized within larger beliefs and experiences within the everyday lives of Cubans living in a changing Cuba.

In Chapter seven, A Framework For Organizing the Diversity in Health Care Pluralism, a framework of form, function, and meaning in pluralistic health care is developed and illustrated. This chapter also addresses the question of whether or not a universal framework of health care pluralism can be developed, and discusses the potential usefulness and problems of such a model.

---

[8] Acronym for *Ministerio de la Salud Pública*.

In Chapter eight, Conclusions: Toward a Universal Framework of Health-Care Pluralism Based on the Cuban Example, I illustrate how levels of influence and constraining and innovative factors interact in a dynamic fashion to produce new and changing experiences; and suggest possible future directions, including the role of medical anthropology in the study of pluralistic health care systems.

Chapter 1: Cuba: A Social History

In this chapter I provide a historical, cultural, and demographic background of Cuba and its people.

Geography, Topography, Climate, and Regions

Geographically, Cuba is located 144 kilometres south of the Florida Keys, 210 kilometres east of the Yúcatan Peninsula, and 60 kilometres west of Haiti. Three mountain ranges account for 35% of Cuba's total land mass; and are separated by two plains, which account for 65% of the island's surface area, and 95% of Cuba's population. More than half of the island is considered arable, but Cuba is limited to producing tropical crops because most of the arable land is at sea level (Pérez, 1995:3-8).

In terms of climate, the average winter low in Cuba is 21 degrees, and the average summer high is 27 degrees. The rainy season occurs between May and October, and Cuba often experiences hurricanes and tropical storms (Pérez, 1995:8).

Regionally, Cuba can be divided into four distinct areas: Occidente, Las Villas, Camagüey, and Oriente. Occidente is the largest region; and includes the provinces of Pinar del Río, Havana, and Matanzas. Occidente accounts for almost 30% of the national territory, and about 40% of the population. It stretches from Cabo San Antonio to

Santa Clara. The region of Las Villas accounts for 20% of the island's area and 20% of the population, and is bordered by the Guamuhaya mountain range in the south (Pérez, 1995:9).

Oriente is home to 25% of the Cuban population, and it includes 20% of the national territory. It is the most mountainous of all the regions, with the Sierra Maestra serving to isolate the region from the rest of the island. Cuba's cultural history can be more easily understood in the context of east vs. west. It was in the east that Afro-Cuban communities developed and the west where the Spanish-Cuban communities developed (Pérez, 1995:12).

A Social History of Cuba and its People

Despite the fact that Cuba is geographically a Caribbean island, Cubans self-identify themselves as Latin Americans. According to *Groliers Encyclopedia* (1995), Latin America comprises the Spanish and Portuguese-speaking areas of the Western Hemisphere - Mexico, most of Central and South America, and part of the West Indies. The main distinguishing factor of the Latin American cultural area is its language and colonial history as opposed to the English and French-speaking Caribbean cultural area; so while a country (e.g., Cuba) may be geographically Caribbean, it may also be culturally Latin American.

However, Latin American 'culture' is not easily defined. It is a complex, syncretic phenomenon that varies according to time and place, as well as between groups and individuals. Its history is one in which various groups of people with divergent worldviews came together, sometimes forced and sometimes voluntarily (Fuentes, 1985).

Part I: Pre-Columbian History

Most of the available information on Cuba's Pre-Columbian inhabitants comes from archeological discoveries and studies of village sites and burial grounds. These sources indicate that at least three cultures, the Guanahatabeyes, the Ciboneyes, and the Taínos existed on the island in late pre-Columbian times (Suchlicki, 1974). The ancestors of these groups may have migrated from the west across the Yúcatan Channel, from the north across the Florida Straits, and/or from the south from the Antillean archipelago (Pérez, 1995:14). It is difficult to ascertain the population of native peoples in Cuba prior to 1492; for example, Peréz (1995:20) estimates 112,000, Suchlicki (1974:4) estimates 60,000, and the *Handbook of South American Indians* (1941:542) reports that estimates range from 16,000 to 600,000.

The Guanahatabeyes are considered the oldest indigenous group; living in caves in the most western part of Cuba, in the Peninsula de Guanahacabibes. They subsisted on fruits and mollusks, and had shell gouges and spoons as their principal artifacts (Suchlicki, 1974; Rudolph, 1985). The Ciboneys were part of the larger Arawak group, and occupied the western and southwestern peninsula. The Ciboneys are referred to as being more 'advanced' than the Guanahatabeyes[9], practicing elementary agriculture, living in rudimentary homes, hunting, and fishing.

The third and major group of pre-Columbian peoples in Cuba was called the Taínos, who, like the Ciboneys, were also members of the larger Arawak linguistic group. The Taínos lived in the central and eastern parts of Cuba; and were the most recent of the three groups, arriving in the late 1200s, only 200 years before Columbus. The Taínos had a more sedentary social organization. Besides fishing and hunting, they introduced agriculture to the island. They cultivated maize, beans, squash, peanuts, manioc, and tobacco; and they had pottery, used polished stones and carved wooden artifacts for tools. Their houses, called *caneyes* or *bohíos*, were made out of bamboo and thatched palm; and were grouped in villages. They were ruled by *caciques* or *behiques*, whose functions comprised those of priests, doctors, and chiefs (Suchlicki, 1974; Rudolph, 1985; Ortiz, 1991; Peréz, 1995). By the late 1400s, the Ciboneys had been more or less incorporated into Taíno society as a lower class, often used as servants. Also at this time, the Carib peoples were making periodic raids on the Taínos, as they moved north out of South America.

In terms of the impact of Cuba's aboriginal peoples on post-Colonial culture, most sources indicate that it is minimal at best (Peréz, 1995; Suchlicki, 1974; Weatherford, 1988).[10] There was little intermingling between the Aboriginal groups and the Spanish, and later; the Africans. African and Spanish cultures are said to have almost replaced the Aboriginal cultures and societies, and still today the Aboriginals' contribution to a national Cuban identity is seen as minor (Suchlicki, 1974; Weatherford, 1988).

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[9] Ortiz 1991 and Peréz 1995 make no mention of this group.

[10] One notable exception is Dr. José Barreiro of Cornell University, who maintains that the Taíno are not extinct; and that they have recently began reasserting themselves as a distinct cultural group in the eastern regions of Cuba (personal communication, 1999).

Part II: The Colonial Era, 1492-1898

The occupation of present-day Latin America and much of the western United States by the Spanish or Portuguese began in 1492 when Christopher Columbus landed in San Salvador Island in the Bahamas. Later, in 1500, the Portuguese expedition of Pedro Cabral landed on the eastern shore of Brazil. In its formative years, the Portuguese colony was faced with many threats to its control of Brazil, such as the occupation by the Dutch in 1630-1654 of the sugar lands around Recife and to the north of Brazil, where the French, Dutch, and British all succeeded in establishing small colonies -- French Guiana, Dutch Guiana (now Surinam), and British Guiana (now Guyana). The Spanish, however, were able to establish control without serious interruptions from other European powers (Barton, 1997; Burns, 1994).

Soon after Spanish and Portuguese contact, trading posts were established and the Spanish system of *encomienda*, predominant from Mexico to Peru, developed (Suchlicki, 1974). Originally this system bound Aboriginal communities to Spanish settlers who were responsible for Christianizing the indigenous people, while utilizing their labour and reaping the produce of their land in the form of tribute. However, the abuse of the Aboriginal peoples, warfare, and the lack of resistance to European diseases such as smallpox, resulted in the decimation of many indigenous populations. As a result, the Spanish began importing African slaves into the depopulated lowland tropical areas.

The major cultural groups imported to the 'New World' from Africa for use as slaves included the west African Ashanti, Yoruba, Ibo, and Dahomey; the Hausa, Amalinke, and Mandingo of the Muslim area of North Africa; and the Bantu of the central Congo area (Davis, 1995a). The role and cultural impact that various African groups had and still have in Latin America and the Caribbean varied with time and place (Davis, 1995a). In Cuba the most influential group was the Yoruba (Knight, 1970).

Tannenbaum (1946) argues that slavery differed in Latin America and the United States. In the United States, due to the strong capitalist/merchantile ideology, slaves were viewed as nothing more than a commodity to be owned by the colonizers; whereas in Latin America the role of the Catholic church and the laws of manumission countered such views; and maintained that the slaves as well asw Indians were in fact human beings, albeit of a lesser kind. Furthermore, unlike slavery in the United States, Cuba's African slaves were kept together in their original tribal groups; and were therefore better able to retain certain elements of their various traditional African cultures (Klein, 1967; Stanley, 1997).

However, the diversity of the African experience within Latin America and the Caribbean cannot be overemphasized. The African experience is not static; it differs by region; and cannot be easily defined by economic, political, or social paradigms. For example, most countries had abolished slavery by 1860; however, Cuba and Brazil maintained this system until the late 1880s. Due to the persistence of the institution of slavery and the comparatively high number of slaves introduced (exceeding even the numbers that arrived in the U.S.), the African presence made a strong impact on these two countries (Davis, 1995a).

The commingling of the various groups of people throughout Latin America and the Caribbean was widespread and very influential in the formation of new cultural forms. However, it was variously encouraged and discouraged by dominant political forces, depending on the country.

> The commingling of the races inevitably accompanied the development of the New World. Contact among Europeans, Aborigines, and Africans created a mixed people - Afro-Creoles - and facilitated a distinct New World culture through mestizaje, or the combining of elements of distinct cultures. Extensive miscegenation between the native populations and Africans in some regions forced the Spanish to create a legal category for them: the zambos. The Portuguese called them cafuzos. In colonial Mexico the Spanish felt so threatened by intermarriage between natives and Africans that they declared it illegal (Davis, 1995b:xiv).

In colonial Cuba, laws prohibited interracial marriages; however, widespread cohabitation and other sexual arrangements created a large *mulatto*[11] population (Martínez Alier, 1989). In many countries throughout Latin America, mixing of ethnic groups resulted in the formation of a social caste system based on colour, in which blacks occupied the lowest status. This caste system collided with a developing class system based on economic considerations whereby one's racial mix largely determined one's socioeconomic status (Davis, 1995a). By the end of the 19th century, most Latin American national societies had become predominantly mestizo or mulatto. Mestizos formed the majority of the national society in areas with highly localized concentrations of indigenous communities such as the Andes, Central America, and Mexico. In tropical regions with small surviving indigenous populations such as Cuba, mulattos made up the majority. As a result, the mulattos and mestizos became the middle class, and blacks and indigenous peoples became the lower class. The upper class was comprised of light- skinned mestizos or mulattos as well as old Spanish and Portuguese families who declared themselves white. However, this was not an impervious division; and many individuals crossed class and social boundaries by mixing with the more fair-skinned populations in the hopes that their children could ascend the socioeconomic ladder (Davis, 1995a).

In the first half of the 16th century, Cuba played an important role as a base for Spanish expeditions to Mexico, Florida, Venezuela, Colombia, and Peru (Pérez, 1995). As a result, Cuba prospered because exploration stimulated economic expansion. However, by the 1550s, with the discovery of silver in Mexico, Spain's interest in Cuba began to diminish. Other European powers were quick to notice Cuba's strategic value, and tried to take advantage of Spain's negligence (Pérez, 1995:34). The French fleet occupied Havana in 1537, and France continued to exert her influence throughout the 1540s and 1550s (Pérez, 1995). Consequently, Havana was fortified in the late 16th century; and quickly became a Spanish political and military center. In 1594 Havana became a city; and in 1607, Havana officially became the capital of the island (Rudolph, 1985).

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[11] Cubans refer to any person who is visibly mixed (black and white) as a mulatto.

In time, Cuba indirectly benefited from events abroad, such as the American and French revolutions in the late eighteenth century. The independence of the United States opened new consumer markets for Cuban products; and the French Revolution provoked political turmoil in the overseas colonies, leading to a revolt by the majority black and mulatto population in the French colony of Saint Domingue (modern day Haiti) in 1796. Slave revolts, widespread killing of white planters, and burning of cane fields led to the destruction of Saint Domingue's sugar industry. An estimated 300,000 French and white Creole refugees fled to Cuba, and brought with them their skilled mulatto laborers as well as their more advanced sugar technology and managerial skills (Rudolph, 1985). Cuba quickly became the leading exporter of sugar to Spain (Rudolph, 1985; Pérez, 1995). The new prospects for the sugar industry prompted the crown, by a royal decree of 1791, to allow the importation of slaves free of duty for six years (Pérez, 1995).

The British occupied Havana between August 1762 and February 1763, opening the city to free trade with all nations and fostering the importation of goods and slaves at low prices. This period of British occupation, important for the development of the sugar industry, was also marked by the introduction of religious tolerance and Freemasonry to island society. However, this climate of religious freedom was not easily shared with the Spanish crown (Rudolph, 1995).

Overall, by the end of the 18th century, Cuba was in a state of transition. Its population was increasing at a rapid rate, to the point where Havana was one of the largest cities in the New World by the end of the 18th century (Rudolph, 1985). Cuba's economy was expanding and diversifying. With Spain involved in the European Wars of the late 18th and early 19th centuries, the United States was in a good position to take advantage of the situation. In 1798, for the first time, Cuban trade with the United States exceeded trade with Spain (Pérez, 1995:69-72).

By 1824 Spain had lost all its American possessions except for Cuba and Puerto Rico, which remained colonies as a result of widespread local opposition to independence (Pérez, 1995). Furthermore, the Monroe Doctrine was passed by the United States Congress in December 1823. The Monroe Doctrine defended the rights of the newly independent republics against foreign interference, while at the same time supported the rights of the Spanish domination in Cuba (Suchlicki, 1974).

Between 1850 and 1877, there was a dramatic shift in trading patterns. By 1877 the United States accounted for 82% of Cuba's total exports, followed by Spain (6%) and England (4%) (Pérez, 1995). Spain's importance to Cuba had diminished relative to that of the United States; and Spain could neither guarantee adequate markets for Cuban goods, nor sufficient supplies (Pérez, 1995). Despite this situation, Spain refused to relinquish control over Cuban affairs; and continued to regulate Cuban trade by levying customs duties on imports and taxes on exports, thereby lowering profits for Cuban producers and increasing prices for Cuban consumers (Pérez, 1995:84-85; Suchlicki, 1974).

On October 10, 1868, Carlos Manuel de Céspedes and a group of planters proclaimed the independence of Cuba in the historic *Grito de Yara* (Cry of Yara). Initially, there was no mention of the issue of slavery; but as the military campaign went on, it became clear that revolutionary success depended upon uniting all Cubans against Spanish rule (Rudolph, 1985). Men like Antonio Maceo, a mulatto from Santiago de Cuba, and Máximo Gómez, a black Dominican exile, were dominant figures in the revolutionary effort. After a few military victories, the nationalist forces controlled approximately half of the island. However, the Spanish government retaliated and launched the Ten Year's War (Suchlicki, 1974). After a great deal of destruction to the island, and an estimated loss of

50,000 Cuban and 208,000 Spanish lives, the Ten Year's War came to an end with the signing of the 1878 Pact of Zanjón. Under this pact, the Crown agreed to enact reforms (Suchlicki, 1974).

The next rebellion was organized in New York by a group of veterans of the Ten Year's War under General Calixto García, one of the few revolutionary leaders who had not signed the Pact of Zanjón (Suchlicki, 1974). In 1878 he organized the Cuban Revolutionary Committee in New York, and issued a manifesto against Spanish despotism (Rudolph, 1985). As a result, *La Guerra Chiquita* (The Little War) began in Cuba on August 26, 1879. However, the revolutionaries were quickly defeated, and the war was over by September 1880 (Suchlicki, 1974). Even though this defeat had a tremendous impact upon the exiled revolutionaries and plans for a future uprising came to a halt, the idea of fighting for Cuban independence was not abandoned (Rudolph, 1985).

In 1880 the Spanish approved the abolition law, which provided for a period of eight years of *patronato* for all slaves liberated according to the law. This system made little difference to the slaves, because under the *patronato*, they were required to spend those eight years working for their masters at no charge. However, on October 7, 1886, slavery was abolished in Cuba by a royal decree that also made illegal the *patronato* (Stanley, 1997).

In 1882, because the much promised and awaited reforms did not materialize, anti-Spain sentiment began to rise among the Cuban population. Meanwhile, Cuban-born José Martí was busy forming the *Partido Revolucionario Cubano* from New York, where he was living in exile, having been expelled from Cuba by the Spanish for his political activities. Martí envisioned an independent Cuba with a strong central government that not only provided protection for its citizens, but also redistributed Cuba's wealth in a fair and equitable manner (Suchlicki, 1974).[12]

From New York, Martí began to plan and organize a new war against Spain. In 1895, Martí, together with General Máximo Gómez and General Antonio Maceo, began the War of Independence in 1895 (Suchlicki, 1974), which lasted until 1898, claiming the life of Martí within the first few months, the life of Maceo midway through the war; and eventually resulting in the American occupation between 1899 and 1902; exactly as Martí had feared (Suchlicki, 1974).

III. Post Independence, 1898-1959

In 1898, the US stepped in and declared war on Spain in what became known as the Spanish American War. This war began and ended in the same year; and resulted in the Americans taking Cuba, Puerto Rico, and the Philippines from Spain in the signing of the 1898 Treaty of Paris (Rudolph, 1985). Cuba was now under American occupation until 1902.

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[12] In many of the interviews I carried out in Cuba, José Martí was repeatedly extolled as a hero who fought for a free and socialized Cuba, his popularity seemingly

On February 25, 1901, Senator Orville Platt introduced in Congress the Platt Amendment, which was ratified on June 12, 1901, as an annex to the Cuban constitution of 1901. The new constitution provided for universal suffrage, separation of church and state, a popularly elected but all-powerful president who could be reelected for a second term, and a weakened senate and chamber of deputies (Suchlicki, 1974:96-97). The Platt Amendment[13] required that Cuba accept the legitimacy of all acts of the military government, permit the United States to purchase or lease lands for coaling and naval stations; and gave the United States special privileges to intervene at any time to preserve Cuban independence, or to support a government capable of protecting life, property, and individual liberties (Benjamin, 1977). On May 20, 1902, the US occupation of Cuba ended; and Tomás Estrada Palma, former successor to Marti as head of the Cuban Revolutionary Party, became the first elected president of the new republic (Suchlicki, 1974).

The years immediately following independence did not see any major or political problems similar to those of many other Latin American nations after breaking with Spain. This situation was largely due to the fact that Cuba had no large unassimilated indigenous populations; and, although there was a large black population, no major ethnic conflicts, no strong regionalism, and no strong church to challenge the authority of the state (Suchlicki, 1974). However, in the 1920s, as a result of a sharp drop

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exceeding that of either Fidel Castro or Ernesto "Che" Guevera.

[13] The Platt Amendment was finally repealed in 1934 (Benjamin, 1977).

sugar prices, Cuba began to see a strong resurgence in Cuban nationalism. This nationalism spread, based on anti-American sentiment, the desire to retrieve national wealth, and the wish to end political corruption and economic dependence on a single crop (Rudolph, 1985).

In May 20, 1925, an anti-corruption campaign and strict control of the government bureaucracy soon became an instrument of tyranny (Rudolph, 1985). There was increasing conflict between then President, Gerardo Machado, who was supported by American and other foreign business interests, and the Cuban labour movement, whose leaders were being harassed and deported for speaking and acting against government policies. Machado's police were known for their use of violence and brutality, especially toward the leftist student groups that were growing and becoming more active (Rudolph, 1985; Suchlicki, 1974). However, Machado had the strong support of United States investors who, by 1929, had acquired US$I.5 billion worth of property in Cuba (Rudolph, 1985).

In 1928, through a fraudulent election, Machado had himself re-elected for a six-year term to end on May 20, 1935. At the same time Machado passed the extension reform which abolished the vice presidency (Suchlicki, 1974). However, the Wall Street crash of October 1929 created poor economic conditions in Cuba; and within a year foreign trade dropped to one-tenth of the 1929 level (Rudolph, 1985). As a result, United States bankers declined to participate in any major undertakings. In the general populace defaults and bankruptcies were common, leading to a rise in unemployment. Machado resorted to heavy foreign borrowing while cutting imports. The Depression had a strong impact on Cuba and political and social discontent grew (Rudolph, 1985).

Student protests in Havana led to widespread repression and the closing of the University of Havana and many other educational institutions. A group of Cuban intellectuals, called ABC, counterattacked the repression with bombings. Machado's gunmen became a common sight in the streets of Havana. Several uprisings were attempted but were harshly crushed. Hatred against the Machado regime continued to grow, and even the United States' support of the regime began to diminish (Rudolph, 1985; Pérez, 1995).

In 1933, Assistant Secretary of State Sumner Welles was appointed ambassador to the Republic of Cuba. Welles traveled to Cuba, and offered to mediate between Machado and the growing opposition. A general strike was called to force Machado's resignation, and the military withdrew its support for the regime. The opposition grew stronger, and Machado finally fled to Nassau on August 12, 1933 (Rudolph, 1985). Welles and the revolutionary leaders appointed Carlos Manuel de Cespedes provisional president. The presidency of Cespedes was short-lived; and on September 4, 1933, he handed rule over to a five-member civilian executive committee that ruled for six days until another man, Dr. Ramón Grau San Martín, a professor who held strong support from both labour and students, was appointed provisional president (Suchlicki, 1974). However, the country remained in a state of chaos, mainly owing to the economic crisis, made worse by bad harvests and the continuing fall in sugar prices (Rudolph, 1985).

The Grau regime enforced several policies that favoured both labour and education (Rudolph, 1985; and Suchlicki, 1974). Part of the reforms involved restricting the role and control of foreign investors on the island, making Grau very unpopular with the United States and other foreign interests (Suchlicki, 1974). The Americans' refusal to recognize Grau's presidency, combined with the lack of support of the communists, who saw Grau as a moderate, resulted in his forced resignation on January 14, 1934, by Army Chief Fulgencio Batista (Suchlicki, 1974). Batista then appointed Carlos Mendieta as Cuba's provisional president. Over the next twenty-five years, despite numerous presidents that held office in Cuba, in reality it was the US-supported Batista, who through de facto or actual presidential powers, held control over the Cuban presidency (Benjamin, 1977).

An important change implemented by Batista was the transferring of the military from civilian to military control. Batista institutionalized the military into his presidency, and used it to consolidate his power. Batista ruled in his name from 1940 until 1944 as a constitutional president. However, when he became president again in 1952 as a result of a coup, he served the next seven years as a dictator (Benjamin, 1977).

The 1950s were characterized by high rates of unemployment and under-employment, vast inequalities between urban and rural living, and a one-commodity, foreign-trade oriented economy (Benjamin, 1977; Rudolph, 1985; and Suchlicki, 1974). At this time sugar accounted for 85% of Cuba's exports, and it became clear by the 1950s that sugar was not a growth industry that could be used as a base for development (Jenks, 1970).

On July 26, 1953, a group of revolutionaries led by Fidel Castro Ruz attacked the Cuban army barracks at Moncada. Castro was a well-educated lawyer and son of a successful *peninsular* who dreamed of revolutionizing Cuba. Castro had been deeply involved in student politics; and very much exposed to nationalism, leftism, and revolutionary thought (Skidmore and Smith, 1992). While the attack on Moncada was unsuccessful, nonetheless its symbolic value gave Castro's movement national prestige. Following the attack, Fidel Castro and his brother Raul Castro were sentenced to fifteen years in jail (Suchlicki, 1974). At his sentencing, Castro delivered his now-famous address, *History Will Absolve Me*. Later, Castro refined his *History Will Absolve Me* address that detailed his political program. Some after, thousands of copies of Castro's address were being made and distributed throughout Cuba (Pérez, 1995).

In 1954, Batista held a mock election in which he ran unopposed and was self-appointed for another four-year term. This 'election' angered the Cuban populace; and discontent continued to grow, with opposition groups becoming more and more united in their common struggle against Batista (Suchlicki, 1974). Batista, worried about the increasing opposition to his rule both within Cuba and abroad, granted amnesty to many political prisoners in an attempt to improve his image (Skidmore and Smith, 1992). This move allowed Castro to flee to Mexico to plan and organize the revolution.

Castro returned to Cuba in 1956 with his brother Raúl, and an Argentine doctor named Ernesto 'Che' Guevara as leaders of the 86-member 26th of July revolutionary movement (Skidmore and Smith, 1992). Their return was intended to be an invasion and part of an anti-Batista uprising. When the expected revolutionary uprising failed to develop, Castro and his surviving revolutionaries fled to the Sierra Maestra mountains; and began to build an army of guerrilla warriors to fight against the Batista regime (Suchlicki, 1974).

The revolution gained new hope in 1958 when the U.S. government placed an embargo on arms shipments to Batista forces, and the Catholic church asked for a peaceful resolution to the violence taking place on the streets of Cuba (Suchlicki, 1974). Batista called an election for November 1958 in a last-ditch effort to pacify his opponents. The voters abstained, U.S. support waned, and Batista handpicked his successor. On January first, 1959, Batista escaped to the Dominican Republic; and on Castro's orders, Guevara and Camilo Cienfuegos led the rebels into Havana. Castro did not enter Havana until January 7, after he had become a worldwide, revolutionary hero (Skidmore and Smith, 1992).

IV. The Cuban Revolution of 1959

Immediately following the 1959 revolution, U.S. concern and worldwide debate focused on the issue of the kind of revolutionary government Castro would ultimately establish. During the first few weeks following the revolution, Castro initially held the position of commander-in-chief of the armed forces, with Manuel Urrutia as president, and José Miró Cardona as prime minister. However, in mid-February Miró Cardona resigned; and Castro formally assumed the duties of prime minister and commander-in-chief (Suchlicki, 1974).

In 1960, following the visit of Soviet Deputy Premier Anastas Mikoyan, Cuba signed a major trade agreement with the Soviet Union; and soon after nationalized all oil companies and remaining US-owned properties. On April 1, 1961, Castro declared the revolution to be socialist and in December of the same year, declared himself to be a Marxist-Leninist (Suchlicki, 1974). On April 17, 1961, Cuban exiles, trained and armed by the CIA, invaded Cuba at Playa Girón in what is known as the Bay of Pigs invasion. After three days of fighting, the Cuban exiles were defeated by the Cuban army.[14]

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[14] For a detailed description of the events surrounding the Bay of Pigs invasion from the perspective of the American fighters, see Johnson, 1964.

Relations between the US and Cuba hit their lowest point when, in mid-1962, the Soviets moved missiles and bombers into Cuba, leading to the historical 'Cuban Missile Crisis' (Kennedy, 1971). However, the weaponry was soon removed under US supervision in exchange for an American agreement to the Soviet Union that they would not incite another Cuban invasion (Patterson, 1994).

In February 1960, Castro's government created a Central Planning Board to plan and direct the country's economic development (Suchlicki, 1974).[15] The transformation of Cuba's private enterprise system into a centralized state-controlled economy resulted in growing inflation and a decline in agricultural productivity; and by 1961 food rationing was introduced. By the late 1960s, Cuba's economy was plagued by low-productivity and shortages. Furthermore, long-term agreements to supply the Soviet Union with sugar put a stop to plans to diversify Cuban exports (Suchlicki, 1974).

In October 1960 the Eisenhower administration banned all US exports to Cuba with the exception of foodstuffs, medicines, and hospital supplies[16] as a response to the issuing by the new Cuban government of Resolution 1 under law 851 which ordered the expropriation of 26 of the largest US companies operating in Cuba. This was only the beginning of what would become the longest trade embargo in history. Following is a chronology of the main steps taken by the US government in the early

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[15] For a Cuban perspective on the history and philosophy of the market reforms in Cuba, as well as current economic restructuring, see Vilariño Ruiz, 1998.

1960s, the formative years of the US trade embargo against Cuba (American Association for World Health, 1997):

- January 1961: US severs diplomatic relations with Cuba.
- September 1961: Foreign Trade Assistance Act of 1961 authorizes the President of the United States to establish and maintain a "total embargo upon all trade between Cuba and the US."
- February 1962: Kennedy administration extends the embargo to prohibit Cuban imports to the US. One month later the embargo is again tightened to prohibit imports into the US from third countries of goods made from or containing Cuban materials.
- August 1962: Congress amends Foreign Assistance Act of 1961 in order to dissuade third countries from trading with Cuba. It prohibits US assistance "to any country which furnishes assistance to the present government of Cuba."
- July 1963: US Treasury Department produces the Cuban Assets Control Regulations Act which freezes all Cuban-owned assets in the US; and forms a prohibition on all non-licensed financial and commercial transactions between Cuba and the US and between Cuba and US nationals, including the spending of money by US citizens in the course of travel to Cuba.[17]
- May 1964: US Commerce Department revokes its prior general license policy for export to Cuba of foods, medicines, and medical supplies; and adopts a broad policy of denying requests for commercial sales of food and medicine to Cuba, permitting only limited humanitarian donations.
- July 1964: Organization of American States (OAS) passes a resolution obliging its members to enforce a collective trade embargo on Cuba which excludes sales of foodstuffs, medicines, and medical equipment[18] while the US persists in its own domestic policy of denying licenses for such sales.

Drastic consequences to Cuba were largely averted because of the relationship that Cuba had forged with the former Soviet Union. The close ties Cuba held with the USSR and other Soviet Bloc countries meant that

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[16] Imports from Cuba continued to be allowed under a general license.

[17] In March 1977 the Carter administration removed restrictions on travel to Cuba by US citizens.

[18] In July 1975 the OAS repealed the regional trade embargo against Cuba, prompting the Ford administration to end the ban on third-country subsidiary trade with Cuba; and instead required only that US companies obtain individual licenses for transactions involving their overseas subsidiaries (Hufbauer et al., 1990).

over 85 percent of Cuba's trade fell outside the reach of the embargo. However, the embargo also forced Cuba, still struggling for autonomy, to develop an increased dependence on the Soviets.

One of the most formative aspects of Latin American culture over the last 500 years has been the widespread occurrence of uprisings against the regional Spanish administration (Frank, 1969). The tradition of Latin American revolt stems from a long history of local opposition to domination by Spain. According to Weatherford (1988), often these 'revolts' were "dismissed as 'uprisings,' as though the Indian were much too primitive to have a high degree of social consciousness or any notion of political ideology" (Weatherford, 1988:160). In fact, according to Weatherford (1988), the so-called localized uprisings of indigenous peoples in 18th century Latin America paved the way for the more successful Creole and mestizo revolutions of the 19th and 20th century, such as the wars for independence in the early 19th century, and the Mexican revolution of 1910.

However, indigenous revolts in Latin America were quite different from those of the Spanish-Creole or African-Creole populations. The 1959 Cuban revolution is a perfect example of such differences. Cuba, "being one of the least Indian countries in America" (Weatherford, 1988:162), had a more European, Soviet-style revolution. However, it is a mistake to assume, as many have (e.g., Oppenheimer, 1993), that the Cuban revolution was merely imported from communist Russia. Revolutions are by their very nature born out of concrete local circumstances, despite the American insistence that all Latin American political activity that does not fall within its narrow range of tolerable behaviours is somehow the product of a Soviet plot (prior to 1990) or of one misguided yet charismatic communist. Revolutions must have a local base, whether Aboriginal, African, Spanish, or any combination.[19]

However, the Cuban revolution was particularly influential with other non-Aboriginal populations in Latin America. For example, the Sandinista revolution in Nicaragua was attempting to emulate a Cuban style revolution, and was strongly supported by the white and mestizo population; however, the Aboriginal Nicaraguans resisted the Sandinista movement as yet another threat to their identity (Weatherford, 1988). In this century alone there have been violent revolutions in Mexico, Cuba, Nicaragua, and El Salvador; Guatemala and Chile have initiated change through popularly elected governments; and Costa Rica, Dominican Republic, and Venezuela have seen more evolutionary, yet slow moving progressive change.

Following the 1959 revolution, race and gender relations in Cuba changed dramatically in both practice and policy. There was an influx of women into the workforce following the revolution. By 1974 25% of the Cuban workforce was made up of women; by 1989 the number rose to 38% (Rosenthal, 1992). There are, however, almost a hundred jobs that remain listed as unsuitable for women (down from over 300) in Cuba; and labour policy makers argue that division of labour in this way does not conflict with the principles of equality. In 1989 7.8% of women were listed as unemployed compared to only 2.5% of men.

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[19] In fact, many hypothesize that Che Guevera was unsuccessful in Bolivia because he was trying to "import" Cuba's revolution.

As a result of the increasing number of women in the workforce, drastic increases in the level of education that women now receive, and access to safe abortion procedures (Singh and Wulf, 1991), the population growth rate has decreased significantly, with women in Cuba having an average of 1.83 children as of 1989 (see also Smith and Padula, 1996).

Following the revolution, the Castro government diverted a large amount of resources to the development of health care, education, and universal employment (Iatridis, 1990; Santana, 1987). As a result, Cuba, despite being classified as an underdeveloped country, maintains social indicators that are better compared to those of a developed nation (see Table I for a comparison of Canada and Cuba's social indicators).

The Cuban revolution had a dramatic effect not just on the socioeconomic reality of day-to-day life in Cuba, but it also significantly changed what it is to be 'Cuban.' While living in the shadow of the U.S. has proved to be a primary factor in the assertion of a general Latin American political, diplomatic, and cultural identity since the 19th century, in Cuba this situation is even more intensified. For example, Carlos Franqui, the Cuban revolutionary who eventually broke with Fidel, maintains that the Bay of Pigs operation and the CIA intervention against Castro only served to strengthen the Cuban regime; and further permitted it to clamp down on its enemies. This occurred because CIA activities following tne revolution in Cuba made most Cubans believe that to oppose Castro was to be against Cuba and for the U.S. (Fuentes, 1985).

Mona Rosendahl (1997), who has conducted the first social anthropological study of Cuba since the work of Oscar Lewis and his team in the late 1960s (Butterworth, 1974, 1980; Lewis et al., 1977a, 1977b,

Table I - Comparison of Social Indicators of Cuba and Canada

Social Indicators	Canada	Cuba
Life Expectancy (in years)	†76 male 82 female	†74 male 78 female
Infant Mortality Rate (1,000)	†6	9.4 †9 ¶7.9 ±6.5
Annual Number of Under 5 Deaths (100,000)	3	2
% Adult Literacy Rate	97	98
% of Infants with Low Birth Weights	6	9
% of Population with Access to Health Services	100	99
% of Population with Access to Safe Water	98	93
% Immunization of DPT	93	100
Doctor:Patient Ratio	1:478*	‡1:240 §1:214
Number of Hospital Beds:Person Ratio	1:152*	1:148*
% of Primary School Children Reaching Gr. 5	96	96

Sources:
UNICEF, 1996
¶ statistic given for the year 1996 by the American Association for World Health, 1997.
* Grolier's 1995
‡Nayeri, 1995
†WHO 1999
§MINSAP, 1995
±statistic given by Cuban Minister of Public Health, Carlos Dotres for the year 1999.[20]

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[20] There has been some debate over the reliability of statistics gathered by the Cuban government (Eberstadt, 1986), but investigations have revealed that the statistics are accurate (see Santana, 1988; Hill, 1983).

1978), reports in her ethnography, which focuses on the day to day lived reality of political ideology in Cuba, that Cuban identity may be defined as consisting of two main factors: being a revolutionary and having *cultura*. Being a 'good revolutionary' requires that one participate in voluntary work (e.g., literacy campaigns, mass organizations, helping during the harvest season, etc.), live according to the Marxist ideals of the state, and be sacrificial in terms of his or her individual wants and needs. To have *cultura* (literally culture, but with a different connotation) is to be generous, kind, and accommodating to others.

Oscar Lewis, in his renowned study of 'the culture of poverty,' made an exception to his theory based on his fieldwork in post-revolutionary Cuba in the late 1960s:

> On the basis of my limited experience in one socialist country - Cuba - and on the basis of my reading, I am inclined to believe that the culture of poverty does not exist in socialist countries. I first went to Cuba in 1947 as a visiting professor for the State Department. At that time I began a study of a sugar plantation in Melena del Sur and of a slum in Havana. After the Castro revolution I made my second trip to Cuba as a correspondent for a major magazine, and I revisited the same slum and some of the same families. The physical aspect of the slum had changed very little, except for a beautiful new nursery school. It was clear that the people were still desperately poor, but found much less of the despair, apathy and hopelessness which are so diagnostic of urban slums in hope for a better life in the future. The slum itself was now highly organized, with block communities, educational committees, party committees. The people had a new sense of power and importance. They were armed and were given a doctrine that glorified the lower class as the hope of humanity (1974:475).

For every negative stereotype of the staunch Cuban communist dictatorship, there is a glorious portrayal of triumph and independence embodied in the Cuban revolution. For example, the biography of a Cuban sugar plantation worker, named Angel Santana Suárez, details a very harrowing and exploitive existence in post-slavery but pre-revolutionary Cuba. Suárez lived through the revolution, and ends his story with the following statement:

> now after the triumph of the revolution, my situation, like that of all the sugar workers, improved one hundred percent. The hated dead time disappeared, and the enterprises which had exploited us so much passed into the hands of the people (Machín, 1987:88).

Today, more than 40 years after the triumph of the revolution, the majority of Cubans never experienced the revolution. It is becoming more and more difficult to maintain an unconditional allegiance to the revolution, especially in the face of increasing scarcities and poverty. More and more open critique of Cuban political and economic policy is surfacing as Cuba is forced to reconcile its Marxist ideologies within the forced entrance into the capitalist market economy.

V. The Special Period, 1989 to Present

The year 1989 marked a dramatic change in world politics, with the fall of the Berlin wall, which was soon followed by the collapse of the Soviet Union and other socialist bloc countries. It was assumed that the blow this caused to the Cuban economy would surely precipitate its demise. However, when the Cuban government announced that this event would not deter its socialist mandate, the American government responded with the most severe policy measure yet taken, when US President George Bush signed the Cuban Democracy Act (CDA) in October 1992. This act gave the US Treasury Department the power to impose fines of up to $50,000 for violations of the embargo, prohibits foreign subsidiaries of US companies any trade with Cuba (90% of which was in foods and medicines), and prohibits ships from loading or unloading cargo in US ports for six months after delivering cargo to Cuba (even if carrying humanitarian goods).[21] This act led to a reported 8.7 million dollars more spent by Cuba on shipping medical imports from Asia, Europe, and South America between the years 1993 and 1996 (American Association for World Health, 1997). Although embargo legislation since WWII has usually included exemptions for humanitarian goods (Krinsky and Golove, 1993; Hufbauer et al., 1990), the 1992 embargo legislation on Cuba does not permit sales of food; and requires unprecedented "on-site verification" for the donation of medical supplies. The legislation does not state that Cuba cannot purchase medicines from US companies or their foreign subsidiaries; however, such license requests have been routinely denied (Garfield and Santana, 1997).

In Cuba, the combination of the loss of Soviet support due to the collapse of the regime, the implementation of the CDA, and the devastating effects of Hurricane Andrew in 1993, is known as *The Special Period in the Time of Peace,* usually referred to as simply *el periodo*

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[21] American Association for World Health, 1997.

especial. It is not possible to talk about contemporary Cuba without addressing the current economic crisis that the eleven million inhabitants of the island must live with. The Special Period has forced Cuba's government to implement many changes in virtually every aspect of Cuban society. The strategy of the Special Period, when implemented in the autumn of 1990, was fourfold: first, to reduce consumption of oil and other products through rationing; second, to increase production of staple foods through the colonization of new land, shifting surplus labour to the countryside, extending irrigation and draining techniques, and introducing new seed varieties; third, to pursue foreign investment through joint earnings; and, fourth, to facilitate the economy's reinsertion into world markets by undertaking management and selective structural reforms (Zimbalist, 1992).

Between the years 1961 and 1989, between 70 - 90% of all Cuba's international trade was with the Soviet Union and other Soviet Bloc countries. By 1990 Cuba suffered an annual loss of 4-6 billion dollars in subsidized and bartered trade, and overnight all imports required hard currency (Garfield and Santana, 1997). In a two-year period the economy retracted by 35 percent, evaporating an annual average growth rate of 4.3 percent in the previous decade. The 60% decline in Cuba's gross domestic product as a result of the factors of the special period is one of the steepest ever recorded (Krinsky and Golove, 1993).

The effects of the CDA on the Cuban health care system cannot be overstated. Although Cuba's economic crisis from 1989 to 1992 led to a rapid decline in imports, medical supplies were partially exempt. It was following the signing of the CDA that the sharp decline in medical imports occurred. Well after the fall of the Soviet Union, Cuban business with US subsidiary companies had continued to grow, reaching $718 million in 1991, the last year before the CDA was passed, which, as previously stated, was 90 percent food and medicine. Between 1992 and 1995, a total of only $0.3 million was licensed for sale by the State Department in response to Cuban government requests to purchase hundreds of millions of dollars worth of food and medicine (American Association for World Health, 1997; Garfield and Santana, 1997). This development further led to the dollar value of imports for health plummeting from $227 million in 1989 to $67 million in 1993[22] (Garfield and Santana, 1997). Today medical products produced outside the US cost Cuba an estimated 30% more and require 50-400% higher shipping charges. Between 1990 to 1994, the number of laboratory exams provided in Cuban hospitals declined by 36%, and the number of x-rays declined by 75%. Of the 1297 drugs available in 1991, there are now only 889 available to the Cuban health care system; and at least a third of these are unavailable at any given time. Furthermore, because most major new drugs are developed by

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[22] There was some recovery; in 1995 the value for health imports was reported to be $104 million.

US pharmaceuticals, Cuban physicians have access to less than 50% of the new medicines available on the world market. Cuban physicians are further denied access to any medical information generated in the United States (American Association for World Health, 1997).

Recent corporate buyouts and mergers between major US and European pharmaceutical companies have further reduced the number of companies permitted to do business with Cuba. For example, in 1995 the American-owned pharmaceutical company Upjohn merged with the Swedish Pharmacia, which since 1970 has made multimillion dollar sales to Cuba of protein purifying equipment, reagents for clinical laboratories and production plants, chemotherapy drugs, cell-site ports to be used in the administration of chemotherapy drugs, and growth hormones. Though technically Upjohn could have applied for a US export license and continued to supply Cuba with some of these items, the company decided instead to terminate Pharmacia's sales, and closed down its Havana office within three months of the merger (American Association for World Health, 1997).

The embargo, and more specifically the CDA, has, through impacting other areas of the Cuban economy, indirectly caused many other health-related problems throughout Cuba. In fact, The American Association for World Health's (1997:4) study of the impact of US policy on the health of the Cuban population concluded that not only has the US embargo of Cuba dramatically harmed the health and nutrition of large numbers of Cubans, but states that "It is our expert medical opinion that the US embargo has caused a significant rise in suffering - and even deaths - in Cuba."

This suffering has taken many forms. For example, about half of all calories and protein intended for human consumption was imported to Cuba in the 1980s. Between 1989 and 1993 this amount declined by 50%, and per capita calorie and protein availability from all sources dropped by 18% and 25% respectively from 1989-1992 (Garfield and Santana, 1997). The decrease in daily caloric intake resulted in an increased incidence in malnutrition, babies being born with low birth weight, and anemia affecting 50% of pregnant women and infants up to 12 months in 1991 (Garfield and Santana, 1997). Between 1991 and 1993, an epidemic of optic neuritis and polyneuropathy occurred in Cuba, affecting over 50,000 people. The primary cause remains unproven; however, it is usually attributed to a rapid decline in food intake and other essential vitamins such as the vitamin Bs[23] (Tucker and Hedges, 1993). Since 1992 the entire population has been provided with monthly vitamin supplements to help prevent the spread of this epidemic. Likewise, a lack of fats formerly imported from the Soviet Union has resulted in a severe shortage of soap and soap products. A lack of soap and other personal hygiene products has been associated with epidemics of pediculosis and scabies, which reached their peak in 1994 (Waitzkin et al., 1997). The sharp decline in oil and gas imports has led to a situation in which often ambulances are unable to perform emergency services because there is no gas to run them. In fact, while most ambulances were in working order in the 1980s, fewer than half were running in 1994.

In March 1996, despite strong international pressure to ease restrictions placed on Cuba by the embargo, the US government passed The Helms-Burton Act (also known as The Cuba Liberty and Democratic Solidarity Act). This act seeks to obstruct economic recovery under the present Cuban government by discouraging foreign investment in the country. This act allows foreign companies to be taken to court in the US if they are found to be participating in either direct investments in former US citizen-owned properties in Cuba nationalized by the government, or any activities that benefit an investor in such properties (American Association for World Health, 1997).

Cuba is not the only country that is affected by the US embargo against Cuba. Recently many American politicians and medical professionals are realizing that the embargo may be having negative effects on the US health care system as well. For example, medical delegates from the US learned of two new vaccines recently developed in

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[23] Román 1994 states that the clinical syndromes were identical to that of Strachan's disease, suffered by World War II prisoners of war subjected to nutritional

Cuba that are not available in the US: one for leptospirosis, a micro-organism that can cause kidney failure, and another for a form of viral meningitis (Claiborne, 1999). Waitzkin et al.'s 1997 report on primary care in Cuba describes some of the low- and high-technology developments in Cuba, which remain largely inaccessible to US health-care professionals. Furthermore, last year US Governor George Ryan went to Havana to meet with Fidel Castro; and declared upon his return that the embargo is not only hurting Cuba but the US as well (Clairborne, 1999).

The current form of the US embargo against Cuba is in direct violation of many international laws. According to the Inter-American Human Rights Commission of the Organization of American States, these regulations violate international human rights accords, including the American Declaration of the Rights and Duties of Man, the Charter of the Organization of American States, and the Universal Declaration of Human Rights, to which the US is a signatory (Garfield and Santana, 1997). United Nations embargoes against Southern Rhodesia, South Africa, Iraq, Libya, Haiti, and the former Yugoslavia, and US embargoes against China, North Korea, Vietnam, Cambodia, Uganda, Iran, and Nicaragua, have all contained provisions for access to basic humanitarian goods such as foodstuffs and medicines (Garfield and Santana, 1997).

Many people ask why the US would maintain such harsh policies against Cuba despite the ending of the Cold War and, by extension, any

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deficiency in tropical prison camps.

real threat to the US national security. Bernell (1994) argues that US hostility toward Cuba will continue for as long as Fidel Castro is in power:

> His words and deeds, even his mere presence, continue to fuel US hostility. He led the Cuban Revolution to communism and toward the Soviet Union - and away from the US orbit. He seized the property of US nationals, denounced the United States itself, and expressed his determined opposition to his northern neighbour at almost every possible juncture for over three decades. And now, despite the loss of his Soviet ally and supporter, he still professes his commitment to communism and continues to berate the United States <...> Accepting the Cuban revolution and making peace with Castro - ending the embargo, allowing travel, and ceasing to demand free elections and free markets as a precondition for normalizing relations - means giving in to the individual who defied the US and got away with it. So the US will not, almost cannot, accommodate him. To do so would mean that, once again, history would have absolved Fidel. This would represent the ultimate failure of US policy toward Cuba (Bernell, 1994:98-99).

Even as I write this dissertation, American-Cuban hostilities continue, this time involving a custody battle over six-year-old Elian Gonzalas.[24]

The Cuban government has responded to the special period by reworking many aspects of Cuban society.[25] For example, Cuba has made a reversion to bicycles as the predominant mode of transportation, to deal with the extreme shortages of gasoline that make owning and operating a car prohibitively expensive for the majority of Cubans, and that has made the public transportation system extremely unreliable. In fact, with only two years of their mass introduction in 1990, the number of buses in Havana decreased by half and the number of cars by two-thirds, while the number of bicycles increased by twenty-five times.[26] To accommodate these changes, the Cuban government has built bicycle lanes along sides of roads; and many roads have been closed to cars and designated for bicycle only.

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[24] This custody battle has since been resolved; and deemed a victory by the Cuban government, with the return of Elian to his father in Cuba.

[25] For a pessimistic review of such changes see Centeno and Font, 1997.

In the agricultural sector, in 1990 pesticide and fertilizer imports fell by roughly 80% and food imports fell by more than half (Rosset and Benjamin, 1995). Cuba was left with virtually no foreign exchange to buy imported pesticides and fertilizers, and little oil to run tractors. As a result, between 1991 and 1993, Cuba made what is known as the world's most immediate and far-reaching changeover from chemical-dependent agriculture to low-input sustainable agriculture[27]. Large tracts of land have been switched from export crops to food crops. Instead of relying on the state to provide all their food needs, work centres and community groups are now planting their own vegetable gardens. Large, state-run farms were replaced with co-operatively owned farms in 1993; and free agricultural markets were reopened in 1994[28] that grow and sell organic fruits and vegetables. In fact, Cuba is now even exporting this information to other countries that wish to become more sustainable in the area of agriculture, as evidenced by the Cuban Association for Organic Agriculture's first international meeting with 180 Cuban delegates and 35 foreign delegates in May 1993. The United Nations Development Program heavily funds this research because Cuba's agricultural reforms are now being used as an international model (Rosset and Benjamin, 1995).[29]

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[26] Personal communication with Eduardo Rojas, Ministry of Transportation, August, 1997. The number of cars in Havana seems to have increased recently with the slight upturn in the economy.

[27] For a detailed account of this changeover, see Rosset and Benjamin, 1995.

[28] The Cuban government has experimented with free agricultural markets previously but closed them down in 1986 when it was declared that they were "promoting a new class of merchants and exacerbating inequality" (Deere, 1995: 13).

In terms of preserving energy on the island, Cuba is experimenting with wind and solar energy. The government has already built more than 250 solar ovens, and people are being trained in their maintenance and use. Within the sugar industry, as of 1994, 104 of Cuba's 160 sugar mills are now totally powered by the cane's own waste, saving the island 3.5 billion tons of oil. Furthermore, cane fiber is being used to make paper and other products; and wastewater from the refining process is treated biologically and returned to the fields as organic fertilizer (Rosset and Benjamin, 1995).

Beginning in 1991, alternative and traditional forms of health care were introduced into the official health care system to deal with the disappearance of many pharmaceutical drugs in the once well-stocked pharmacies. Cubans refer to these changes as *resolvar*[30] (the verb to solve or to deal with a situation); and many see them as necessary measures to preserve the socialist character of the state, while others see them as a last ditch effort on the part of the government, the beginning of the end of the communist system.

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[29] These farms are organic in order to deal with the loss of over 80% of pesticide and fertilizer imports. However, the UNDP has taken notice of this initiative, declaring Cuba the first country to make a nation-wide conversion to organic farming (Rosset and Benjamin, 1995).

As previously stated, this thesis is primarily interested in one of the *resolvares* - the changes in the Cuban health care system. In 1991, as a response to the special period, the Cuban Ministry of Health began considering seriously the traditional home remedies used by many Cuban elders and *campesinos*[31]*;* and began to collect information and run scientific tests on such traditional remedies. Furthermore, many doctors have come from China and Korea to teach Cuban doctors about traditional treatments in those countries. As a result, health care indicators have continued to rise (Chela, 1998); acupuncture is now a part of Cuba's general medical curriculum, and there are currently over a thousand family doctors using it in their practices.[32] Furthermore, many Cuban doctors can receive a specialization in traditional medicine, homeopathy, or acupuncture. It appears that the government, the medical profession, and the population in general have enthusiastically embraced this new system of health care delivery, now official policy in Cuba.[33] As a result, Cuba's health care system is in the process of being transformed from a largely biomedical, albeit preventive and community-based system, to a pluralistic system[34] of health care delivery.

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[30] *Resolvar* is also used in reference to getting things on the black market.

[31] Cuban word for people living in rural areas of Cuba.

[32] Marta Perez, Director of Traditional and Natural Medicine for the Province of Havana. Personal communication, November 9, 1998.

Aspects of Modern Cuban Society

The most drastic change implemented in the Special Period has been the introduction of certain capitalist measures that for some Cubans has meant access to many formerly unattainable goods, resulting in a higher standard of living. For others it has meant that their formerly adequate salaries are now barely enough to survive. But, for most, these changes are difficult to reconcile with the hegemonic socialist doctrine with which they were raised.[35] In the Special Period, many Cubans have experienced an agonizing decline in their standard of living, as basic necessities have become scarcer, their currency has been devalued, and many of the items they once received cheaply from the Soviet Union have all but disappeared. In fact, during the years 1987-89, immediately prior to the Special Period, an average 84.2% of Cuban imports came from Eastern Europe and the Soviet Union; therefore, the collapse of the Council of

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[33] Based on information gathered through interviews, discussions with health care practitioners, and participation in health related conferences in my previous trips to Cuba. In 1994 Cuba introduced a policy document called "Resolution 9" which details the use of various traditional and alternative therapies. This document is detailed in Chapter four.

[34] Pluralistic health care occurs when there are two or more available health care systems to choose from. This is discussed further in Chapter three.

Mutual Economic Co-operation (CMEA) and the economies of Eastern Europe and the Soviet Union together led to a 60% reduction in Cuba's overall imports. Cuba further lost approximately $4 billion on imports from the CMEA between 1989 and 1991 (Zimbalist, 1992). Cubans are now forced to obtain many basic necessities, which they once received on their *libretas*[36] in the state-run *bodecas,*[37] on the black market, which obtains most of its goods through pilfering of supplies from factories and delivery centres or common thievery; and is now a proliferating part of the Cuban economy. Zimbalist (1992) argues that the current economic situation in Cuba is similar to the conditions in 1969. However, in 1969 morale was high, as most Cubans felt they were a part of a larger socialist community, and felt eager to build the new society. With the collapse of the Soviet camp, and with the majority of Cubans having been born after the revolution, morale has declined. As a consequence support for the revolution has weakened.

One of the responses made by the Cuban government to the current economic crisis was to abandon its policy of guaranteed employment, and legalize the use of the American dollar, in July 1993. This action has resulted in the creation of a class society in which those with access to

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[35] For an excellent ethnographic account of how socialist ideology is experienced within the everyday lives of Cubans prior to the special period see Rosendahl, 1997.

[36] The ration card that all Cuban citizens possess.

[37] The stores where rationed goods are purchased.

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through family abroad, work in the tourist sector, or through numerous entrepreneurial activities, enjoy access to many goods and services, while those who do not have access to the dollar must go without (Pastor and Zimbalist, 1995).[38] The Cuban government has even opened up its own kiosks to exchange American dollars and pesos at the street rate (currently 21:1) instead of the state's official rate of 1:1. This situation has led to much frustration, as Cubans are forced to deal with the bizarre reality that a taxi driver generally earns several times the salary of a doctor or an engineer. Cubans generally attribute this problem to tourism that has now replaced sugar[39] as the country's number-one producer of hard currency.

The social effects of the economic crisis are constantly played out in Cuban humour, which portrays many of the frustrations felt by Cubans who are trying to adjust to their rapidly changing society. For example, I was told a joke about a man who is drinking in a bar with some friends, boasting about his job as a waiter in Veradero. After several drinks the man offers to buy a round of drinks for all the customers in the bar. The patrons eagerly accept his offer. When it comes time to pay the bill, the man has no money and is therefore taken away by the police. Later, his wife arrives at the prison and pleads with the police to let her husband go, "Please, my husband gets a little crazy when he has been drinking. He cannot afford to buy drinks; he is not a waiter but only a brain surgeon." The cruel irony of the joke effectively summarizes the results of a communist system trying to save itself through capitalist measures. Another saying I heard on numerous occasions was a play on words; people said that in order to survive in Cuba today one must have *fe* - meaning literally faith but in this case an acronym for *familiares en el extranjero* (family members or friends abroad).

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[38] It is estimated that approximately 15% of Cubans have *regular* access to dollars through commercial endeavours, work in the tourist sector, or family living overseas (McFayden, 1995); however, while living in Cuba, it quickly became obvious that many more Cubans who live near areas visited by tourists, have irregular access to dollars.

[39] The price of raw sugar on the world market fell from 13.6 cents per pound during November, 1989- September 1990 to 9.1 cents per pound during November, 1990-September, 1991. Furthermore, Cuba's sugar harvest decreased from 8.1 million tons to 7.6 in the same period. This led to a loss of 100 million dollars in hard currency earnings

Women In Cuba

With the revolution came great change for the role of women in Cuban society: prostitutes were reeducated for other work; rural women traveled to Havana to learn to read and sew; young educated women traveled to rural areas with the literacy campaign, teaching others to read; the Committee for the Defense of the Revolution and the Federation of Cuban Women[40] built day care centres for women who went to work outside the home; and the maternity code gave women maternity leave and the guarantee of their previous job when they returned to work (Smith and Padula, 1996). Despite a slow economic situation in the 1980s and the promise of full employment only to men, by 1984 36% of the workforce were women (Smith and Padula, 1988). The Cuban government passed the

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in 1991. The assumption of shipping costs previously defrayed by the Soviet Union cost a further $150 million (Zimbalist, 1992).

Family Code in 1975 which states that men and women are equal partners in marriage with equal rights and responsibilities, and therefore must both work in the home and hold equal responsibility for all children born in or out of wedlock (Smith and Padula, 1996).

The Federation of Cuban Women (FCW) was established in order to give women a platform for political action, to debate and have their concerns heard by higher-level political institutions. I know few women who participated in the FCW. One person even told me that she used to go to FCW meetings but now did not because "Nothing ever changes. We make resolutions and everyone gets excited but then nothing happens." Another woman friend told me that the FCW was a great idea; and that the reason people are discouraged is because the government does not have the financial resources to realize the resolutions passed, and so people feel that the FCW has become ineffective. She maintained, however, that women should continue to attend on principle, and maintain the structure of the organization for the future. I attended two FCW meetings while residing in Alonjas. While I found most of the discussion to be progressive, centering around ways in which life could be made easier for women, and how men need to start fulfilling their duties in the home, there remained an underlying assumption that it was the responsibility of women to educate men and make them fulfill their responsibilities in an equal partnership (see Rosendahl, 1997:74-77 for a discussion on the

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[40] Started by Vilma Espín, wife of Raul Castro.

problems with the FCW in the rural community where she did her fieldwork).

Today the position of women in Cuban society is very challenging. Women seem to be caught between the progressive view that women should have an equal position in society, espoused in the government's revolutionary rhetoric; and the reality of persisting traditions and cultural ideals that believe a woman's place is in the home taking care of her husband and children. Mona Rosendahl (1997:58-61) uses the terms *la calle* versus *la casa* to illustrate the division of gender in Cuba. *La calle*, or the street, is an emic concept defining the ideal social space of men; and *la casa*, or the house, is an emic concept defining the ideal social space of women. There was certainly a trend toward this sort of division in the neigbourhood where I stayed. Men could often be found playing dominoes and drinking rum in the street with their friends, at discos or parties with or without their wives or girlfriends, or just loitering about in the street. Women, on the other hand, were usually at home when they were not at work, leaving the house only to walk the children to and from school, to go to the *bodeca* or agro-market, or to stand in front of their home to talk to other women passing by. A man who had a wife or girlfriend who spent time on *la calle* would often be ridiculed for having no control over 'his woman'; and rumors would start that she was *le pega tarros*[41] literally 'putting horns on him,' a phrase that refers to unfaithful acts toward one's partner. Men, on the other hand, seem almost expected to carry on extra-marital affairs; but are expected to do so in a discrete fashion so as not to shame or embarrass wives and family.

During my own fieldwork, I questioned two men whom I knew were having extra-marital affairs about their indiscretions, telling them I was interested as to why they would carry on a relationship with another woman when they appeared to be happy with the women they were already with. The first man told me it was OK because the second woman did not know his wife or any of her friends, and so she would never find out and therefore never be hurt. The second man told me he loved his wife very much and never wanted to lose her, so he felt he must be very discrete because she was very jealous and if she knew would surely leave him. Then why do it? I asked. "Because I am a man, I can't help it. Just as a woman has natural desires to be a mother, men have natural desires to have sex with many women. But I only love one woman," was his reply.

Likewise I saw this division of labour and social space being transmitted in the family. One family I knew well had two teenage children. The boy was teased about having many girlfriends and staying out all night, and was even permitted to bring different girls home with him to spend the night in his room. The girl, on the other hand, was encouraged to stay home and help her mother with the household chores, and spend time on her schoolwork. When speaking about their children, they would often say "Teresa is a good girl but Alfonso (laughs)... *un veradero hombre* (a real man)!" During my interviews one woman told me

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[41] It was explained to me that there is a difference between *tarros* and *tarritos*, the latter being a small indiscretion like a onenightstand, whereas the first is more serious,

> In Cuba most women must work three jobs - her work outside at the school, the hospital or wherever, her job as a mother, and her job as a housekeeper. Most men in Cuba do not help at home, and the woman must do everything. Look at my husband! Do you ever see him helping me at home? Does he ever do the dishes, the floor? Not all men in Cuba are like this but the majority - yes!

This statement reflects a common sentiment that I found among many of the Cuban women that I spoke with and knew; but certainly not all women felt this way, as there are many men who take their household responsibilities very seriously. One older woman, Adela, was very happy with the help that her husband gave around the house. Both Adela and her husband Lazaro were retired; and Lazaro did a lot of the cooking and cleaning, and would often run errands for Adela. He also helped her take care of her very elderly father who lived with them and required constant care. Another young man of approximately 25 years who lived on my street often helped his mother with household chores. When she was away, he became the primary caretaker of the household that consisted of himself, his parents, and his girlfriend. He told me that he was responsible

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where a person will carry on an affair for some time or even flaunt the affair.

for all the household chores when his mother was away because his father and his girlfriend know nothing about housework. "If I am to make a life with my girlfriend, I am afraid that I will always have to do all the cooking because she does not know how to cook. I think that her mother taught her nothing about cooking." I spoke with two other Cuban men about the fact that many Cuban women complain about the fact that men do not do their fair share of the housework. Both then made pointed efforts to demonstrate to me that they did in fact do housework. When I went to the house of Alberto, I found him cooking lunch for his young daughter and himself. "Look, Tracey, do you see me cooking? Come in and have some of this delicious lunch. I am a great cook, even better than my wife!"

When my own boyfriend at the time came to visit me in Cuba, the occasion revealed Cuban ideals about the role and division of labour between men and women. At first many Cubans thought it was strange that he would have let me come to Cuba by myself in the first place. Once he arrived, a couple of people on my street teased him about helping with the laundry and dishes, laughing and telling him it was woman's work. Furthermore, during the day when I went to work at the clinic, he and my research assistant would sometimes go out and spend the day together. On such days, I would return home to reports from neighbours about the time they left and where they said they were going. One person even told me that they would never let their man go off with another woman while they were at work.

Basically, the structure for equality between the genders is present in Cuban policy, and Cuban political rhetoric encourages an idealized society where men and women share equally in all responsibilities. However, in Cuba, as in many other countries in the world, there exist long-standing traditions and cultural ideals that place men and women in different positions of social power.

Race Relations and Ethnicity

In the nineteenth century most European writings on Latin America and the Caribbean focused on development issues and not 'racial' issues. Such writings ignored the contributions of Africans and indigenous peoples to the building of Latin America. In fact, the Cuban Fernando Ortiz was one of the first Latin Americans to explain African transculturation, or the transfer of cultural values and rituals from Africa to the new world (see Ortiz, 1991). The 20th century has witnessed a growing number of black consciousness-raising movements within Latin America and the Caribbean. Some examples include *Negritude* in Martinique and Cuba, *Teatro Experimental do Negro* in Brazil, and *Rastafarianism* in Jamaica. In general, pan-African movements identified Latin America as an integral part of the struggle for the rights of Afro-Creoles (see Davis, 1995b for examples).

It is difficult to know the actual population makeup of many Latin American countries, as Afro-Creoles are often misrepresented in official statistics, including national census reports. Further, the collecting of statistics is difficult, as it depends on the perceptions of those gathering the data, the classifications used by different countries, and the self attributions of ethnicity by groups and individuals (Davis, 1995a). For example, Rodolfo Monge Oviedo has published 1992 statistics on Afro-Creoles, providing a range of the available statistics. Some of the more disparate groups include Brazil, which ranges from a minimum of 5.9% and a maximum reporting of 33%; Nicaragua, ranging from 9%-13%; Belize, ranging from 46.9% to 57%; Dominican Republic, ranging from 11% to 88%; and Cuba, ranging from 33.9% to 62%. Other countries such as Chile, El Salvador, and Guatemala do not provide statistics on persons of African descent; and most data from Argentina report zero. The total percentage of Afro- Creoles reported in Latin America and the Caribbean ranges from 9% to 17.2%.

Jack Hopkins (1987), considered one of the most reliable authorities on Latin American demographic statistics (Davis, 1995a), reports that Cuba makes up 2.7% of the total Latin American population; and is 37% white, 11% black, 51% mulatto, and 1% Chinese. In Cuba it is well known that the western part of the island contains a population that is predominantly Spanish, while the east (referred to as the *Oriente*) contains a predominantly African population. Almost all of the indigenous population in Cuba was wiped out by the mid-1600s by the Spanish colonizers. In fact, in the autobiography of Estéban Montejo, a Cuban slave who lived through the last 26 years of slavery in Cuba, the only reference made to indigenous peoples is to say that: "They had Indians here in the old days" (Montejo, 1995:20). His autobiography is an invaluable source of first- hand information on the racial complexity of Cuban slave society as well as the ethnic distinctions among the African groups in Cuba. Montejo's references to the Chinese-Cuban population are quite negative, and imply very little interaction between the Chinese and African groups until after the abolition of slavery. He also indicates that his knowledge of other African groups expanded once slavery was abolished:

> In the plantations there were Negroes from different countries, all different physically. The Congolese were black-skinned, though there were many of mixed blood with yellowish skins and light hair. They were usually small. The Mandingos were reddish-skinned, tall and very strong. I swear by my mother they were a bunch of crooks too! They kept apart from the rest. The Gangas were nice people, rather short and freckled. Many of them became runaways. The Carabalís are like the Musungo Congolese, uncivilized brutes... I got to know all these people better after slavery was abolished (Montejo, 1995:25).

Slavery was finally abolished in Cuba in 1886, but widespread racial discrimination remained prevalent; in fact, as late as the mid 1950s, the former president of Cuba, Juan Batista, was prohibited from entering certain nightclubs and casinos because he was of partial African ancestry.

Cuban ideology speaks of Cuban nationality as embracing all cultures and ethnicities, and yet there remain some reports of discrimination based on skin colour in Cuba. In fact, in 1959 Castro gave a major address entitled "Proclamation Against Discrimination," exposing the discrimination existing in Cuba in both work centres and places of recreation; and proclaiming the equal rights of all Cubans regardless of ethnicity or skin colour (Marable, 1984). However, Cuba did not enact 'affirmative action' laws until the mid-1980s, even within the Party. Opinions toward racism in Cuba are quite mixed. According to Bengelsdorf and Stubbs (1992:158):

> Although there is an ongoing reassessment of history and culture along racial lines in Cuba there have been no published studies to date whose express intent has been to assess contemporary racial composition or attitudes. Ethnic democratization of Cuba's new political, economic, and sociocultural structures must tackle the racism inherent in obscurant and derogatory notions about Africa and Afro-Cubans. The theoretical contributions of black liberation as much as national or class liberation need to be revisited.

However, Marable (1984) maintains that Cuba's position on blacks both nationally and internationally has been progressive and anti-racist; and that Afro-Cubans in general feel that the revolution has served to enhance their position in society (see also Cole, 1978).

Furthermore, post-revolutionary Cuba has played an active role in the affairs of Africa through its foreign policy initiatives during the cold war era. Cuba has officially claimed that its aid to many African nations is the result of the perceived tie that Cuba has to Africa, due to its large African- Cuban population (see Entralgo and López, 1995). However, McGarrity (1992) maintains that despite the Cuban revolution's expressed symbolic identification with and provision of material and strategic support for liberation movements on the African continent, the internal aversion to black cultural movements has meant that many Afro-American exiles who went to Cuba, encouraged by Castro's anti-racist political stance on an international level, were profoundly disillusioned by the insensitivity and hostility they encountered when they attempted to present their views on international black liberation to important figures within the Communist Party. She maintains, however, that they had little trouble relating to individual African-Cubans with whom they had daily contact.[42] Rosenthal (1992:165) maintains that African-Cuban loyalties to the revolution are a result of both the ideological hegemony of socialism in Cuba, which makes it difficult to realize any alternatives; and the fact that those who experienced racism before the revolution often feel loyalty to the revolution, "if only because they and their children are better treated today."

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[42] For a detailed example of the experiences of one such person, see Clytus (1970).

The perceived lack of attention paid to racial issues within Cuba may not necessarily be due to any underlying racist policies on the part of the government. For example, the Vice President of the People's Power in Santiago told Marable (1984) in an interview that the Cuban government deliberately repressed statistics on Afro-Cubans specifically because they do not wish to discriminate based on colour. Marable (1984:28) concludes that:

> Virtually everyone I talked with in Cuba agreed on one point: racism is officially not tolerated, and the entire population feels a direct and personal link with the struggle for African and Caribbean liberation. Most white Cubans, especially those who have become adults during the Revolution, seem oblivious to racial distinctions (Marable, 1984:28).

In a recent survey conducted by de la Fuente and Glasco (1997), they found that Afro- Cubans do not have a separate history, language, religion, or homeland; but share these attributes with the rest of the population. This conclusion is based on interviews with 200 Cubans on questions of racial tensions within Cuba, in which their responses were more easily classified according to generation rather than ethnicity. They found that racism in Cuba is not institutionally tolerated, but exists in the form of mental prejudices held by certain individuals. One important finding was that only 4% of whites and 7% of blacks believed that there should be an all-black organization in Cuba.

Cuba has struggled throughout its history to assert itself as a nation whereby individual Cubans may define themselves as Cuban above and beyond other ethnic classifications. As early as the late 19th century, Cuba as a nation fought for some degree of equality among its citizens. Both the 10 Years War (1868-1878) and the Little War in Cuba (1879-1880) were fought to achieve independence and abolition, but ended with the signing of the Pact of Zanjón that granted neither. According to Terrer (1991), both wars were based on class conflicts within Cuba; but were constructed historically as racially- based wars by the Spanish rulers. In order to do this, the ruling class launched an effective propaganda campaign to convince the population that those who were fighting for Cuba's independence were only the blacks. Any white Cubans caught during the war were forced to sign statements saying that they surrendered when they realized that that the war really was in fact a 'race' war. Furthermore, names of white rebels were removed from lists to make it appear that the war was divided on ethnic lines; and General Guillermón, who led the rebels, was portrayed as a madman, killing whites and stealing their properties. As such, the Spanish succeeded in using the issue of skin colour to divide the forces of insurrection.

While the status of Afro-Cubans in post-revolutionary Cuba remains a highly debated issue (see Brock and Cunningham, 1991), most findings do appear to support the idea that within Cuba, ethnicity is not seen as a major defining characteristic to the degree that it is within North American society; and that racism *per se* appears to take the form of mental prejudices held by various individuals rather than an institutionalized and systematic form. Many of the above views can be supported by several incidences within my own fieldwork. For example, at one public talk delivered to a group of North Americans on the subject of traditional and alternative medicine, one person asked if these treatments were more popular among Afro- Cubans than the rest of the population. The Cuban doctor delivering the talk responded, "I don't know because in Cuba there are no blacks, no whites, nor Chinese. In Cuba, there are only Cubans."

In contrast, within my fieldwork I did hear several comments that I would certainly code as 'racist.' Such comments ranged from "blacks are just like that" to more blatant statements like "I don't like blacks." Furthermore, any time there was news of a robbery, the first question of many individuals was "was it a black?" When I questioned people as to why they assumed the thief was black, they often responded that *todos los ladrónes son negros* (all thieves are blacks). Whenever I expressed that this was a racist comment, people would often act surprised and sometimes became defensive, maintaining that they were not racist. Usually they would further explain that while "all thieves were blacks," "no *todos los negros son ladrónes*" (not all blacks are thieves). This last statement, to me, seems to illustrate a general attitude of many 'white' Cubans I spoke with. While they have many close friends at work and at home that are classified as black (and continually pointed this out to me when I questioned them on racist attitudes), they felt that Afro-Cubans have a tendency toward anti-social behaviours such as stealing. Many Afro-Cubans whom I spoke with, however, seldom complained of racism.[43] In fact, I asked one Afro-Cuban couple about how the special period has affected their lives. They said "at times things have been difficult, but overall the revolution has done a lot for our race; we are thankful for that and we would say that we are revolutionaries." Overall, I found the question of racism to be a very complicated subject in Cuba, one to which North American classifications and attitudes do not necessarily apply.

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[43] I should point out that I met another anthropologist in the field studying the Rastafarian movement in Cuba. This woman told me that many Rastafarians in Cuba did feel that they were discriminated against (she mentioned by the police specifically) because of their appearance in traditional Rastafarian attire.

Chapter 2: Theory and Methodology

In this chapter I describe the methodology I employed in my data collection; and outline the theoretical approach that is used to analyze the data I collected and present in chapters four, five, and six.

Methodology

In September of 1998 I arrived in Havana with a research question and a list of issues that I wanted to explore. My primary intention was to learn how a former exclusively biomedical health care system could transform into a pluralistic system almost overnight, and what form this new system took. However, as was predicted by all those experienced field researchers who warned and advised me before I entered the field, the issues changed and evolved; and the focus of my research shifted. With each answer several questions arose; with each new experience I struggled to attribute meaning; and through the day-to-day life in which it all existed I found myself gradually seeing and experiencing things from a perspective different from the one I had when I arrived.

Social research involving fieldwork is often criticized as being "fraught with uncontrollable variables" (Zieba, 1990:38). It is generally well agreed that when social research is primarily qualitative, the 'variables' become even more 'uncontrollable.' Yet the quality of research and knowledge that can be gained from this type of research is invaluable.

This being said, it is important, despite the qualitative nature of anthropological fieldwork, that anthropologists attempt to conduct research in as objective a fashion as possible. Therefore, in order to maximize the likelihood of producing the most objective and usable results, a combination of independent methodologies must be used. This approach is especially important in cross-cultural research, in which ideas are to be translated from one culture to another (Zieba, 1990:39; Bernard, 1988). Accordingly, this study uses the "triangulation method" outlined by Smith (1981). Simply put, this method uses three methods of data collection within the same study: review of the existing knowledge available (literature review); participant observation; and unstructured, semi-structured, and structured interviews.

Literature Review

As this study will be dealing with two highly political and controversial issues, namely Cuba and the incorporation of traditional medical systems, the need for a comprehensive understanding of the relevant literature cannot be overemphasized. This is because within highly political topics, even more so than other domains, the knowledge negotiated through anthropological strategies tends to be strongly subjective (see Lather, 1986). It is therefore essential that researchers of intensely political topics familiarize themselves with as many positions as possible in order to determine the consistencies and inconsistencies that occur. Any attempt at objectivity within the social sciences therefore requires familiarity and extensive use of observations from a variety of positions.

The current literature dealing with the issue of implementing pluralistic health care has revealed many problems (see Waldram, 1990; Bodekar, 1994; Said, 1994; Zhang, 1994), making the need for research in this area essential. One important type of research involves examining the creation and implementation of pluralistic health care policy in other countries. This thesis uses Cuba's health care system as a case study of a system which, under massive political and economic pressures, has made many adjustments in its health care delivery, the most impressive being the adoption of the World Health Organization's (WHO) recommendation that countries should incorporate traditional medicine into biomedical systems (WHO, 1983) as a way of economizing health care delivery.

The existing literature on Cuba and the incorporation of traditional medical systems provides a rich array of positions from various authors. Each of these positions allows the potential for unique observations; and, taken together, a better understanding of the issues may be gleaned (Sen, 1994). I performed the bulk of my literature review before entering the field not only to ensure efficient use of research time and resources, but also to familiarize myself with the social, cultural, economic, and political issues that surround my topic of research. However, a literature review is an ongoing process; and I continued to research and read in the field and upon my return to Canada.

Participant Observation

The fieldwork portion of this project was carried out in Havana, the capital city of Cuba. I conducted research as a participant observer in two specific locations. The first location was in the policlinic where I had intended to 'work' as a volunteer but ended up participating more as a student. Aside from the occasional favours, odd jobs, answering the phone, calling in the next patient, and distracting small children while their parent or grandparent was being examined, I spent the majority of my time recording doctor-patient interactions, noting patients' comments toward various forms of treatments, and noting day-to-day occurrences. As a result of my participant observation in the clinic, I collected 648 'patient observations.' Some of these observations are very detailed, and others sparsely documented. The level of detail for each one varied depending on a number of factors, including amount of time spent in the *consultorio*, type of illness, if the patient was a repeat or first-time, the number of 'events' that occurred during his or her *consultorio*, and my own personal state at the time of recording. The word 'event' includes, but is not limited to, interruptions, phone calls, *apagones,*[44] and medical or equipment shortages.

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[44] The word used when the electricity goes off.

The majority of my time was spent at the *Policlinico 26 de Julio;* however, I did visit two other clinics with some frequency. One of the clinics specializes solely in traditional and alternative medicine; and I went there on six separate occasions, usually accompanying an elderly friend of mine who was a patient. I would then observe her treatment and ask questions of her doctor, who was very willing to speak with me. The second clinic was actually a research centre for the study of traditional Chinese medicine, but treats patients two afternoons per week. At this clinic I observed acupuncture being practiced by one of the technicians who worked there; and even received a few basic lessons in acupuncture. In addition, I visited and toured several other clinics in the Havana area. As a participant observer in the policlinic, I was allowed to witness firsthand accounts of how new policies are being implemented, how patients are responding to these policies and changes, and which aspects are proving to be successful and which are not.

The second location in which I was a participant observer was the home in which I lived. I lived with a family of six (excluding myself), of which four lived there on a permanent basis. This family consisted of a husband and wife, the mother of the husband (the grandmother), and the husband's three children from a previous marriage (two of whom lived in the house on a part- time basis). While I realize that by the very nature of my nationality and biology I was not a member of the family with which I lived, I did participate in many day to day activities of the family, including some household chores, caring for the youngest child (including occasionally sharing my bed with him), watching the *novela*, and visiting and socializing with neighbours. In fact, throughout my stay with this family, I felt very much 'a part of the family', as they always treated me with a great deal of warmth and affection, for which Cubans are known. Furthermore, both the husband and the grandmother of the family are doctors; thus living in this home allowed me to witness the daily lives of these two doctors outside of their workplace, and allowed me to gain invaluable ethnographic knowledge of a Cuban family and *barrio*.[45]

I also found that through my day-to-day experiences in Cuba, I became more and more familiar with the routines of the people around me. As I came to know people, I found that slowly things that I initially didn't understand began to make sense. In fact I would say that I probably gained most of my insights and research data from simply living in Cuba - making friends, eating dinner with the family, picking up the little boy from school, chatting with the patients in the hall at the clinic, and talking with my neighbors on the street. Browner (1999:136) argues for the importance of this method, stating that is necessary for establishing rapport; and without it we would "sacrifice the ability to assess the impact of the condition on the larger life experiences and communities of those affected."

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[45] Neighbourhood - but where I lived, it was referred to more often as our *calle* or street.

My research as a participant observer fulfilled five important requirements for pursuing interviews:

a) provided experiential familiarization with the Cuban health care system and implementation strategies for new health care policies;
b) allowed first-hand observation of doctor-patient relationships;
c) created a network of contacts for the interviewing stage of my research;
d) provided a ready source of input, validation, and feedback on ideas or issues that surfaced in my notes; and
e) produced general ethnographic knowledge and context.

Interviews

One of the most tried and true methodological tools available to cultural anthropology is the use of unstructured interviews. These can be conducted in a group format (focus groups) or on an individual basis. Initially, I was going to begin the interviewing process for this study by conducting unstructured interviews in the form of focus groups (Agar and MacDonald, 1995). On the basis of these focus groups, I intended to formulate a semi-structured questionnaire for individual interviewing. Instead, I bypassed the focus group stage altogether. There are many reasons why I decided not to use focus groups in my research, aside from the usual problems surrounding participation, accuracy, and representation (see Stewart, 1990; Krueger 1994). My three main problems were: time, organization, and fear.

When I first arrived in Cuba, I needed time to adjust; and get to know people, the clinic, the language, and the system; and I therefore felt that I really did not have the time to conduct focus groups properly. Second, it would have been nearly impossible for me to organize a focus group. Many people are busy with schedules that do not allow the flexibility that would be required in trying to find a common time for several people. I also often found it difficult to get many people to adhere to prearranged appointments, and/or to show up for appointments on time. Third, I did not feel that a focus group was necessarily appropriate, considering Cuba's political atmosphere. While I found Cubans to be very supportive, helpful, and interested in my research, they did not always feel comfortable expressing their views on certain issues in front of other people or around persons they did not know well. This situation became increasingly more obvious to me as time passed, and I got to know some people much better. In fact, one person who volunteered to set up an interview for me with a friend, returned to me the next day and said that the person *tiene miedo de hablar* (is afraid to speak) because he did not know me. As a result of these factors, I abandoned the idea of conducting focus groups. Nonetheless, I believe that through my participant observation I was able to do a better job than had I removed people from a natural setting in which discussions of health and health care made sense, and tried to generate such discussions in a research setting. I did, however, need to find another way to validate and receive feedback on any interview questions that I wanted to ask.

Thus in my sixth month of fieldwork, I generated a list of questions most likely to produce the information I needed. This questionnaire, which was to be used as a guide in the interviewing process, was composed in a series of steps. First, through participant observation in the clinic, and through many discussions with a few key 'informants,' I felt I was able to identify several important themes. On the basis of these themes, I composed a rough draft of the questions I would ask. In order to maximize the breadth of knowledge obtained through the interview process, I focused on creating *descriptive questions* (see Spradley, 1979:78-91). Once the draft questionnaire was created, I was then faced with the necessity of validating the significance and relevance of the questions I wanted to ask. In order to do this, I gave the draft of interview questions to three Cuban friends; and asked them for some honest feedback. One told me that the questions were good, and that he thought I covered everything. The other two were not as satisfied. The second explained that I would need to define my concepts more clearly; and thought that two of my questions were pointless, and that I was sometimes being repetitive in my questioning. The third friend informed me that one of my questions would produce the same answer from everyone, and did not feel that it was useful to my research (for this reason I left it in); and she further felt that two of my questions would make some people nervous for political reasons.

I addressed these criticisms in more or less the same way. One of the questions that the second reviewer thought was a pointless question was "Have you ever used traditional or alternative medicine?" He thought this was pointless because he told me that everyone has used it even though some do not realize it. This is because, he said, many people who use teas in their home do not define it as *medicine*. Instead of deleting the question, I left it in and followed it up with more specific questions. Therefore, if someone told me they had never used traditional or alternative medicine, I would ask them more specific questions, like "have you ever taken an herbal tea to treat an upset stomach?" My friend was right, as everyone in my study that initially answered no to this question later answered yes once the questions became more specific. The second question that my friend thought was pointless had to do with asking doctors if they made or received referrals. He pointed out that all policlinic doctors see patients who are referred by family doctors, and will refer patients who would benefit from some other sort of specialized treatment. Therefore, he felt there was no need to ask this question. I explained to him that I wanted to know specifically about referrals for treatments with traditional and alternative techniques. He then said I would have to make that clear, so I followed his suggestion and again made my question more specific. I addressed his criticism of being repetitive by explaining that often anthropologists will ask the same question in different ways in order to solicit more information on a certain topic. This he thought made sense, but still felt that people might think I wasn't listening to them if I asked similar questions. In response to this, I asked only repetitive questions when I felt that the person wanted to elaborate on a previous idea; or if I felt that the initial question was not well understood. In short, I relied on my own intuition to judge how far I would dig on a certain issue with a certain individual.

The third friend informed me that everyone would answer the question "What are the main challenges to the Cuban health care system in the special period?" with "trying to maintain the health of Cubans at the same level as it was before the special period." She also felt that the question "How do you think the Cuban health care system can improve?" would either be answered with *quita el bloqueo* or silence[46]; and that the question "What do you feel are the advantages and disadvantages to the Cuban health care system in general?" would make those who did not know me well uncomfortable. I left this question in my outline; and I asked it only of people who I felt either knew me well enough to feel comfortable answering this question, or who I felt would not be made uncomfortable by the question; for all others I left it out.

After this initial validation step, the resulting questionnaires (see Appendix I) were used to conduct four test interviews with people I knew well in order to rectify any other glitches that surfaced or had gone unnoticed. In order to maximize the likelihood of receiving information relevant and important to those I was interviewing (as well as to meet my own interests), I asked all interviewees if they had anything they wanted to add, if they had any questions for me, or if there was anything that they thought I should have asked but did not. In the majority of situations, these questions generated numerous questions about myself, my research, the health care system in Canada, and Canada in general. Most people said they could not think of anything that I should ask that I hadn't asked, but one of the four test interviewees said I should ask more about specific treatments. I agreed and from that point on I did. Other interviewees wanted me to ask about specific things that they themselves wanted to know (e.g., one patient requested me to ask a professor or a doctor if traditional medicine in Cuba came from *los indios,*[47] and if so how did they pass on this information. She then wanted me to get back to her with the answer). Whenever possible I fulfilled their requests.

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[46] See Sherriff (2000) for an interesting discussion on silence as a form of cultural censorship on the subject of "race" in Brazil.

Semi-structured interviews were conducted with fourteen doctors, three professors, twelve patients, five politicians, three religious healers, a technician, and a nurse. All interviews were recorded, with the exception of four that were hand-written at the request of the interviewees. Initially I had planned to have people sign forms explaining to them that their names would remain anonymous if they wished, but I quickly realized that this practice only served to make people uncomfortable and/or suspicious of my intentions. So instead I verbally asked all people if I could use the information they gave me; and when appropriate, I asked if they wished to remain anonymous. In a few cases, interviewees appeared to want to say something but appeared to be somewhat uncomfortable. In such situations I assured them that their names would not be used in my research, and they would then usually then speak more freely. In some situations (for example, when interviewing well-known political persons), it was entirely inappropriate to bring up the issue of confidentiality and anonymity.[48]

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[47] Cuba's indigenous peoples are said to be extinct since the late 1700s, although recently much controversy over this issue has surfaced, mostly outside the island.

I followed a semi-structured interviewing format in order to allow the issues to develop through mutual participation and negotiation between myself and the persons being interviewed, as I did not want to limit the conversation to predefined areas. Often conversations and digressions occurred, and I usually allowed them to take their course in order to broaden my information base and my own general knowledge. Each interview progressed differently. They ranged from one that ended up being more of a formal question and answer period, despite my attempts to make the atmosphere and the interviewee more relaxed, to the more common casual conversation while drinking *cafecitas* or *refrescos*[49] and eating *dulces* (sweets). The nature of the interview depended on many things, including the location, time of day, atmosphere, how well the interviewee and I knew each other, and the personality of the interviewee. All these factors were noted in order to control some of the 'uncontrollable variables.' All interviews were conducted in Spanish, with the exception of five individuals who spoke English fluently. In addition to conducting semi-structured interviews, during my first research trip (Sept. 1998 to July 1999) I continued with my participant observation at the clinic.

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[48] To do so would be to imply that the person had "secrets" to tell, or that they wished to complain about the political situation in Cuba.

Other methods of validation were performed as well. After completing a ten-month stay in Cuba, I returned to Canada for five months. During this time the majority of my interviews were transcribed, and I began some initial analysis of my information. I formulated a list of new questions that arose during this process. I then returned to Cuba for two months (Dec. 1999 to Feb. 2000), at which time I asked for clarifications, confirmations, and elaborations from many of the people whom I had worked with and interviewed. Whenever I found a piece of information that seemed strange or out of place, I returned to question the provider of the information; and then asked others about it. Furthermore, I presented some of my initial analyses to two of my friends in Cuba; and asked for validation of my findings.

According to Michrina and Richards (1996), validation occurs when the researcher's description matches the group's understanding. Allowing the research participants to review the researcher's interpretation

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[49] *Cafecita* means literally "little coffee," it is a very sweet expresso that I was offered at almost every home I visited. *Refresco* refers to any cold, sweet drink with the exception of juice.

of data collected tests this validation. This is called the hermeneutic method, and contains three steps which are acted out in a continuous fashion:

> 1. The investigator gathers data pertaining to the research area in a stepwise manner from sources such as written text (literature review), dialogues (focus groups and individual interviews), and observing behaviours (participant observation).
> 2. Hypothesis formation: the researcher attributes some meaning to the data (interpretation).
> 3. Testing of the hypothesis: the researcher constructs an understanding of the whole group through interpreted pieces of data (validation from the group).

Using this hermeneutic method, a meta-model (Young and Goulet, 1994) was developed. A meta-model is a model developed through collaboration between anthropologist and 'informant' who can provide information that remains meaningful and plausible to the anthropologist, the host culture, and the culture that the anthropologist comes from. This does not mean that all parties must agree with the interpretation; however, there must be some collaboration; otherwise it is unlikely that the anthropologist's perception of events will match 'reality.' The meta-model constructed is in a narrative form, and was developed to explain patient treatment-seeking behavior.

This meta-model was developed in two main steps. The first step involved piecing together my own observations and conversations with patients into what I felt was a typical response to illness by a patient in Havana. Once I had formulated this outline, I discussed and reviewed it with three 'informants' (two doctors and one patient). During the creation of the meta-model, there was some disagreement; and it was reformulated a number of times, especially during my last visit; but in the end all agreed that it was a reasonable representation of a 'typical' Cuban patient's treatment-seeking behaviour.

It is important to point out that this method of information gathering has been criticized by the interpretive anthropologists (see Crapanzano, 1992; Clifford and Marcus, 1986; Marcus and Fisher, 1986), who claim that it is not possible to know or ascertain what is in the head of those we study. According to interpretive anthropologists, all culture is subjective; and employing anthropological methods involving cross-cultural comparisons (i.e., attempts at applying 'science' to the concept of culture) will result in a distortion of data and information. I, however, believe that defining knowledge as absolutely local with no relevance outside of its context not only does not allow for comparative study or wider application, but also treats societies (and individuals) as closed systems instead of dynamic, interdependent, and mutually influencing components.

Today, with the increasing rate of globalization, cross-cultural comparisons, instead of becoming obsolete, appear to be more valid today than ever before. The interpretive anthropologists' avoidance of 'objectivity' or 'science' in the study of culture is, in effect, as stated by Moore (1996:6), a "process of radical othering (which) are merely methods of exclusion and hierarchization by another route." Clifford

Geertz himself, credited as the father of interpretive anthropology, has never claimed that empirical replication is not possible (although he does maintain that as of yet no suitable methods have been uncovered for such a process). In a 1990 interview he conducted with Richard Handler (1991:607), he blatantly rejects such a notion; and states:

> I do not believe that anthropology is not or cannot be a science, that ethnographies are novels, poems, or visions, that the reliability of anthropological knowledge is of secondary interest, or that the value of anthropological works inheres solely in their persuasiveness.

During my second trip, I spent the majority of my time investigating the unofficial health care sector, asking why it was still persisting despite the acceptance of alternative and traditional health care techniques by the official sector. I conducted several unstructured interviews on the street concerning the use of the unofficial system. These interviews were done in the company of a friend who is a Cuban doctor. We simply walked the streets, and would stop to talk to groups of people and ask them various questions about their treatment-seeking behaviour. We always began by asking "What do you do when you get sick?"; and would follow-up with questions like "And if that doesn't work?,"; and, "Is there any type of illness that you would not see a doctor for?" The conversation would usually flow very easily; and many people eagerly told me of their experiences with various types of healers they referred to as *yerberas, curanderos, paleros, santeros,* and *espiritistas.*[50] We also went to visit some of these healers in their homes and places of work.

Again, most of them were very willing to talk to us about their professions and practices. I also went to visit some practitioners in the unofficial system with whom I had made contact through other friends who knew of my research interests. One *yerbera* even took me to collect herbs with her; and allowed me to spend a few days with her in her 'shop', watching her interact with her 'patients.' In addition to questioning persons on the street, my doctor-friend (who was very well known by most of the people in this municipality) and I visited many family doctors and nurses; and asked them about their feelings toward unofficial treatments and practices. Often this question led to informal discussions about their own thoughts and experiences with the unofficial sector. This method of information gathering was much more informal than conducting interviews, but I found it to be in many ways even more valuable than the more formal methods used during my first research visit.

Methodological Problems

Although for the most part I found people to be very willing and sometimes even eager to share their experiences with me, I did encounter two recurring problems during my information gathering. The first problem occurred only with a few of the male interviewees. It became clear that they mistook my wanting to interview them as a sign I wanted to date them, and I sometimes found myself warding off flirtations and sexual advances throughout the interview. However, while the Cuban cultural norm encourages flirtatious behavior and sexually charged

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[50] The difference between these will be explained in detail in Chapter six.

male/female relations, all I needed to do to end any unwanted advances was to state firmly that I was not interested. This assertion was usually met with a shrug of the shoulders, and then the conversation would quickly revert to the topic at hand. I quickly learned not to take such behavior personally. The second problem I encountered on a few occasions was that I noticed some persons became uncomfortable with some questions that they perceived to be political. Sometimes I would simply reassure them that all the information I was collecting was confidential, and they would relax and continue to talk. Occasionally they would lean over and shut off the recorder while making some statements; or they would answer with *"yo no sé nada de la política"* (I don't know anything about politics). Of course these perceived problems may not necessarily be perceived as such by the people involved.

Applied Nature of This Project

Due to the current economic climate of cutbacks and downsizing in academia, as in every other facet of society, the stress on anthropological research has moved from the theoretical to the applied (Pelto, 1992). In applied anthropology many interesting methodological questions are raised, as the "product of research must make sense to practical policy-making administrators" (Pelto, 1992:264). In fact, participants at a conference on the "Construction of Primary Data in Cultural

Anthropology" noted that, given the rapid changes now happening in even the most remote research areas,

> each of us has the responsibility to make sure that data are collected in such a way as to document fully the influence of the particular situation on the results of the research and in such a way that others may use them (Bernard *et al.*, 1986:383).

Anthropological research works to do just this. In fact, anthropology can offer ways to recognise factors previously ignored in the discourse on international health care policy-making; i.e., addressing the dubious dichotomy created between the so-called objective and subjective states of health, being the separation of one's biological health and one's experience of his or her health.

This project is first and foremost applied in nature. Simply put, I have no desire to conduct any research that does not have a practical and tangible use. Despite outright attacks on anthropological work that attempts to achieve a practical use (e.g., D'Andrade, 1995), I believe that anthropologists have a responsibility to the people they are working with as well as to their own communities, to attempt to make some sort of meaningful contribution. D'Andrade's (1995) argument that moral models should be kept separate from models about the world is both unrealistic and irresponsible. We have an ethical obligation to those we study and work with. This is not to say that an anthropologist's moral view of the world should ever be imposed; however, it does often imply that in some situations anthropologists should take a stance on issues of social justice and human rights (see Hardin, 1990).

The Issue of Anonymity

Many people that I worked with were not opposed to having their names used, although a few asked that I not attribute some of their words to their real names. Originally I had planned to use the names of those who did not request to remain anonymous, but later decided to make all participants anonymous. I did this for two reasons: first, because I believe that by revealing the identity of some, I may indirectly reveal the identity of others; and second, because I was disturbed by an article in *The Globe and Mail* on June 10, 1999, in which it was reported that a Cuban economics professor lost his job after having critiqued the Cuban economy beyond the boundaries of what he believed to be acceptable and permitted criticism. I have therefore used pseudonyms for all places and people, with the obvious exception of well-known political personalities. I have also in some cases given different names to the same persons; and/or refer to them using generic terms such as 'a doctor,' 'a patient,' 'a man', or 'a woman.' In some cases I have altered details and contexts of certain situations to help maintain anonymity of the people who participated in my research. In all cases I have avoided revealing too much personal information about any one individual.

Theoretical Orientation

The major focus of my thesis is on the relationship between personality, culture, health, and the state. I pay additional attention to the role of globalization in local social policies, and how it affects this relationship.

The primary theoretical orientation for this dissertation comes from psychological anthropology. I will employ Wallace's (1961) 'organization of diversity model', which, simply put, maintains that cognitive sharing is not a functional prerequisite of society. The key that keeps any society functioning is the predictable behaviour of its members, regardless of the multitude of motivations, understandings, and cognitions associated with an event or institution. Wallace's model explains how the different cognitive maps of individuals may produce socially acceptable behavioural interactions, and yet have dissimilar meanings for the participants. However, in addressing rapid changes in society, in this case, the replacement and/or supplement of biomedical treatments with alternative and traditional medical treatments, it is necessary to look at how the organization of diverse meanings is managed at the policy level.

In order to conduct a more comprehensive analysis of culture transformation within contemporary Cuban society, and how this change is manifested within the institution of health care, three additional variables must be incorporated into Wallace's model. First, the dynamic relationship between culture change at the group level and individual models of culture must be addressed. Second, constraining factors, both local and global, associated with the adoption of various cultural institutions, must be addressed. In this study, constraining factors include political and economic power relations that directly affect which institutions will be allowed to develop and change; symbolic, cultural, and ideological constraints at the individual and national level; institutional and class constraints at the national and international level; and constraints placed on the acquisition and availability of resources at all levels. Third, the effects (both constraining and innovative) of the current trend of globalization on local societies and cultures must be factored in, as the process of globalization is essentially adding cultural knowledge while at the same time creating additional constraints. Therefore, theories of culture change (Barnett, 1953), critical medical anthropology (Baer, 1996; Baer, et al., 1986; Scheper-Hughes, 1990), and globalization theory (Hannerz 1992a, 1992b; 1990) respectively, will be incorporated into Wallace's organization of diversity model in order to account for the recent development of pluralistic health care in Cuba. These additional variables will allow for a more comprehensive understanding of how constraining factors are dealt with at local, national, and international levels.

I will argue that individuals, in order to accept, in this case, the new health care policy in Cuba, not only recombine pre-existing mental configurations; but must be able to locate within the new policy, elements that are both coherent and cohesive with the *meanings* attributed to the old system. Therefore, individuals will not likely embrace dramatic change in an institution unless they can find some level of meaning within the new institution that is linked to a pre-existing template in which the new model may root itself. Cognitive maps are not simply reorganized, as suggested by Barnett; but they expand and grow as new meaning is negotiated. This meaning may differ broadly for various individuals; and, as contended by Wallace, the motivations behind the acceptance of the new institution will likely differ from individual to individual.

This project will argue that the facts that the new health care policy in Cuba is drawing partly on traditional knowledge and practices within Cuban communities, and that these changes have not altered the overall structure of the health care system, provide *cohesiveness* between the pre-Revolutionary, revolutionary, and 'special period' health delivery models. Furthermore, the fact that the pre-Special Period health care system was already very much a community-based system, and the fact that the philosophy of most traditional and alternative health care models incorporate many of the ideals of Cuban culture, provides the *congruence* necessary for the successful adoption of this new policy. Furthermore, despite the relatively straightforward boundaries outlined in the official policies, the interpretation and practice of medicine and various therapies, upon closer examination, are in fact interpreted and employed in a wide-ranging multitude of forms by both doctors and patients, providing even more *diversity* within the *organization*.

Chapter 3: The Globalization of Health Care

In this chapter I examine how the globalization of health care policies constrain the implementation of a pluralistic health care system; and includes a discussion on the dynamic relationship between culture change at the group level and individual models of culture, the political and economic power relations that exist within any society that directly affect which institutions will be allowed to develop and change, the effects (both constraining and innovative) of the current trend of globalization on local societies and cultures; and the relationship between social class, poverty, political infrastructure, and health. Furthermore, in this chapter I address the multitude of external factors affecting the form and shape of local health care systems.

Current Trends in Health Care Pluralism

Every society practices some form of medical pluralism. Medical pluralism exists whenever there is more than one medical system existing at any given time within the same community. It is also true that every society has some form of traditional medicine, whether that be legally recognized or not (Vuori, 1982).

Recently, many countries have made the move toward the official incorporation of traditional medical systems into the dominant biomedical framework, with the purpose of reaching the WHO's goal of 'health for all by the year 2000' (WHO, 1979). This move has had varying degrees of success, with some countries refusing to acknowledge traditional medicine legally (e.g., Austria) and others embracing it - according it, at least on paper, legal recognition and structural equality (e.g., China). The WHO promotes medical pluralism because traditional medical systems are existent and functioning, and provide culturally appropriate care; and the use of traditional practitioners can expand the resources to achieve 'health for all by the year 2000' (WHO, 1983).

The most popular case of a pluralistic health care system is the one currently existing in China (see Crozier, 1968; Forgac, 1994; Farquhar, 1994; Kleinman, 1974; Lee, 1974; Young et al., 1995). China's pluralistic system was created because of the lower cost of providing services; but also because it was seen as culturally appropriate, and capable of providing greater access to services for rural people. As mentioned, the WHO advocates the incorporation of traditional medicine into biomedical systems of health care delivery for these very reasons (WHO, 1979, 1983); and claims that China provides the world with an excellent example of a successful synthesis of biomedical and traditional systems. However, Forgac (1994) has found that this system is not as successful as the WHO claims it to be. Based on her fieldwork conducted in a Chinese hospital, she maintains that there is no theoretical integration of the two systems of biomedicine and traditional Chinese medicine (TCM). She concludes that there is little critical analysis available on the integration of traditional medicine and biomedicine, policy approaches are not well documented, and the effects of integration policy on the country's medical system are not well researched.

A Typology of Pluralistic Health Care Systems

There are five basic policy approaches taken to the use of traditional and alternative medical practices. Both Young (1994) and Bodekar (1994) have devised typologies based on the relationship and interaction between western biomedicine and alternative and/or traditional medical systems. Because Young's typology is more developed, I will use his types to outline here the forms that a pluralistic health care system can take.

1. **Intolerant/Monopolistic.** In this system only biomedicine has the legal right to practice. Unofficial medical pluralism may exist; but ultimately traditional medicine is not given legal validity or access to resources, and is frowned upon by the officially recognized system.

2. **Tolerant/Monopolistic.** In this type of system, traditional medicine has no legal recognition but it is tolerated by the dominant biomedical system so long as the traditional medical practitioners do not claim to be registered medical doctors. Once again, biomedicine both maintains structural superiority; and holds sole access to medical resources.

3. **Parallel/Pluralistic.** In this type of system, biomedicine and traditional health care systems are legally recognized; but there is no active collaboration. Furthermore, while in theory individuals have equal

access to both systems, in practice biomedicine often maintains structural superiority and greater access to resources.

4. **Collaborative/Pluralistic.** In this type of system, two or more legally recognized systems exist independent of each other but are engaged in collaboration, usually in the form of a referral system (passive collaboration), or with a group of health care practitioners from different systems working together to diagnose, recommend treatment, and treat the illness (active collaboration).

5. **Integrative.** In this type of system, biomedicine and traditional medicine are merged in terms of both theory and practice. This situation is difficult if not impossible to achieve because of radical differences in both the starting points and the fundamental philosophies between biomedicine and ancient systems such as traditional Chinese medicine. Although it is unlikely that this type will ever exist, the purpose of a typology (Weber, 1947; Gerth and Mills, 1958) is to demonstrate the logical extremes of a continuum. In other words, a typology is a heuristic tool that allows the analyst to specify similarities and differences in real systems.

Of course these typologies describe one aspect of a health care system; that is, the type of care provided. There are many other factors that must be considered (e.g., accessibility, cost, social conditions, degree of the country's technological development, etcetera) when analysing any health care system. Therefore the above-described typology is used to form one dimension of the framework presented in Chapter seven in which I have modeled Cuba's pluralistic health care system, based on the information gathered for this thesis.

Problems in the Development of Pluralistic Health Care Systems

The creation of an officially recognized pluralistic health care system in any of the above forms is often met with considerable conflict at every level of implementation. One of the most pervasive of these conflicts is the role that culture must take in the formation of an effective collaborative health care system. However, much of the literature fails to recognize this point. For example, A. Young (1983) argues that it is possible to separate some of the aspects that make up a medical tradition (knowledge, practices, apparatuses, *materia medica*, and skilled personnel), and use one or more of these aspects to aid the function of biomedicine; e.g., using traditional healers as a vehicle for extending the services of the official sector into local communities, or in adopting their *materia medica* as a cheap alternative to importing expensive drugs. He claims that this practice is better than making attempts to integrate/ collaborate because while integration/collaboration may solve some problems, it creates many new ones such as "strong resistance based on ideological and professional grounds, by official sector practitioners to bringing traditional healers into their clinic" (A. Young, 1983:1210).

Many issues are implied in the above statement; namely, it assumes the administrative and structural superiority of the biomedical system. The point of a collaborative, pluralistic health care system would be to have traditional practitioners operating within the context of their own health care system, not under the supervision or in the space of the biomedical doctor's clinic. The practice advocated by A. Young (1983) does not recognize the value of the traditional medical system itself, and therefore delegitimizes both the traditional medical system and the traditional practitioner's role as a healer. Essentially he is advocating appropriation and not collaboration, an approach endemic to the current literature including the WHO (1983, 1995). Researchers and international policy makers commonly promote the 'integration' of traditional medicine, referring only to the *materia medica.* They do not recognize the theoretical concepts behind traditional medical systems, assuming that the medical value of a traditional health care system can somehow be separated from its cultural value (as defined by Vuori, 1982). Accepting this premise has led to the tendency on the part of many researchers to advocate that in order to 'prove' their efficacy, traditional medical systems should validate themselves in biomedical terms. Such studies make four challengeable assumptions:

1. The assumption that there is a separation between the psychological and the physiological. This distinction is not a cultural universal, as argued by Byng (1993) in his study of mental illness in Nicaragua. He states that he was continuously being asked by his western colleagues why he was not studying more 'pressing' health care issues, namely the presence of diarrhoea, which kills hundreds of Nicaraguan children every year; however, he was never asked this question by the Nicaraguans that he was studying, as the separation between the psychological and the physiological was always arbitrary. Yet many medical anthropologists and international health care policy makers fail to recognize this difference in worldview pertaining to the provision of health care. For example, Browner *et al.* (1988), a team of medical anthropologists, claim that they have devised a methodology to measure ethnomedical data objectively. In actuality their methodology employs biomedicine as the determining factor, despite disclaimers made throughout the article that they do not value biomedicine over traditional medicine.

2. The assumption that little is known about the safety and efficacy of traditional medicine. This assumption has resulted in the focus of many researchers on toxicity and efficacy studies which remove the *materia medica* from its cultural and social context in order to study it 'scientifically.' For example, Zhang (1994) argues that there is a need for research focusing on the training of traditional medical practitioners because of the high number of cases of accidental ingestion of herbs leading to poisoning. The basis of this argument is problematic for two reasons: a) it is assumed that biomedicine is in a better position to evaluate the efficacy and toxicity of medicinal plants than those traditional healers who are already using them; and b) it is assumed that no such efficacy or toxicity studies exist.

Obviously there is a need for efficacy standards in any type of medical practice, but we must not assume that biomedicine can always be used to determine the level of efficacy. In order to make efficacy standards effective and relevant to the health care system in question, they must be determined on their own terms; that is, practitioners of the alternative health care system must be allowed to form their own efficacy standards. Some practitioners of alternative medicine have already done this. For example, chiropractors have devised their own licensing system that serves to recognize those chiropractors that are deemed capable of performing this type of health care. Biomedical evaluation of a traditional health care practitioner demonstrates only whether or not the health care system in question can meet those standards set out by biomedicine, and should not be considered indicative of an effective or non-effective system[51].

3. The assumption that the onus must be on the traditional health care system to prove its efficacy in biomedical terms. For example, Said (1994) argues that there is a 'need' for the scientific study of the Unani system in Pakistan, a system that has been operating for thousands of years; and as she herself points out, serves 80% of the rural population and 65% of the overall population. Similarly, Elkadi (1994) advocates the scientific study of the healing effects of the Koran. According to Elkadi, the scientific evaluation of traditional medical systems will provide a better understanding of how traditional medical systems work; and serve to increase the dialogue between biomedicine and traditional medicine.

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[51] Sometimes a practitioner of a traditional health care system wishes to have their system evaluated in biomedical terms. However, it should be noted that just because the practitioner wishes to evaluate his or her medical practice in this way does not mean that this is necessarily the most appropriate or effective method of determining efficacy. See Morse et al. (1988) for an example of one such experiment and the various issues that arose.

The desire to design such tests has two causes. First, many believers in a particular health care system feel that through providing scientific proof, they can gain credibility in promoting the given traditional medical system; or, secondly, such studies may be conducted with full knowledge that the traditional medical system will not be able to survive the rigorous scientific testing. Normally, the first reason is given by those not involved in the dominant biomedical system; and the second is given by those who are (i.e., biomedical doctors and policy lobbyists - see Waldram, 1990). Nonetheless, any such efficacy tests are always rendered arbitrary, as they remove the system from its cultural context in attempts to separate its medical value from its cultural value.

4. The assumption that biomedical science is a 'culture without culture.' The three preceding assumptions cannot be maintained without also assuming that biomedicine somehow holds an objective, culture-free position from which it may evaluate efficacy and measure results. Stone (1992) outlines how the role of culture in health care planning has been interpreted in the literature throughout the years. Beginning in the 1940s and into the 1950s, the role of culture was considered irrelevant, as it was assumed that all people were reasonable above and beyond their cultural backgrounds. It was therefore further assumed that once these people could see the superior abilities of biomedicine and western medical structures, they would accept and adopt a biomedical health care system. Therefore, in order to replace traditional health care systems with a biomedical system, all that needs to be done is to introduce western knowledge and technology. For obvious reasons this failed to work; namely, it was ethnocentric, and based on the flawed ideals of the prevailing modernization thought of the time.

Today culture is, for the most part at least, recognized as flexible, changing, even adapting. It is viewed as a broader ideological and behavioral context "within which biomedicine can be integrated" (Stone, 1992:410). But more important, it has been suggested that biomedicine itself has a 'culture' of its own. For example, Stone (1992:413) states that:

> The idea of 'cultural' influences on health programs shifts away from an exclusive focus on the local culture of village peoples to a much broader concept which includes the 'culture' of health organizations and health bureaucracies, or even of 'international development' itself.

And this 'culture' brings with it a certain set of beliefs and values that are imposed at the local level through so-called health care development programs. Local meanings and social arrangements are overlaid by global standards and technologies in nearly all aspects of local biomedicine. The global-local exchanges that produce contemporary cultures of biomedicine provide a great opportunity for comparative research. The dynamics of the global-local exchange challenge our notions of 'universalism' in clinical science and 'local' knowledge in clinical practice (DelVecchio-Good, 1995). Focusing on these processes thus causes a rethinking of the boundaries between the 'local' and the 'global' in terms of health care provision (Greenough, 1995).

But where are these values and beliefs being negotiated? They are, in fact, being negotiated at the international level; and today, with the rapidly increasing rate of globalization, we can no longer speak of the local as existing outside of a larger global context. In actuality, biomedicine is dictated through international agencies such as the WHO and UNICEF. It is at this international level where policies are decided and set according to the values and beliefs shared, or believed to be shared, at the international level. It is an interaction of the economics, politics, and culture of those in the decision-making positions that make up the [capital 'B'] biomedical culture. However, many health care policy makers, biomedical practitioners, and even medical anthropologists continue to maintain the belief that biomedical science is a 'culture without culture'; and therefore biomedicine has managed to maintain its structurally superior status within international health care policies. When international policies are imposed at the local level,[52] cultural, economic, and political factors dialogue with the [capital 'B'] biomedical culture that exists at the international level. It is this dialogue that determines how biomedicine will manifest itself at the local level.

The WHO and The Globalization of Health Care Policies

Globalization as a process has influenced the practice of health care throughout the world. In order to understand how health care systems are experienced at the national, community and individual levels, we must know how international policies and practice affect, direct, and constrain practice.

Globalization, Human Rights, and Cultural Relativism

Prior to the Second World War, human rights were seen as the sovereign prerogative of the state; and therefore a domestic rather than an international concern. It was made obvious by atrocities committed during the war that individuals are far too vulnerable if left to the mercy of domestic legal systems. Human rights require protection from the laws and practices of the state. The goal of the UN is to promote universal respect for and observance of human rights and fundamental freedoms for all without distinction of race, sex, language, or religion[53]. While this is an honourable goal, there are two fundamental flaws. First, the UN structure hardly reflects the ideals of equality; i.e., certain privileged nations are accorded all the decision-making power (see Simons, 1994). The second problem is that the family, household, and community are not provided the same level of importance as the individual; and neither is the cultural, social, and economic violation of the rights of indigenous and minority groups.

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[52] International policies are, in fact, imposed,as often acceptance of these policies is tied to aid and access to funding. For example, the signing of Alma Ata was made a condition for continuing aid in many countries.

[53] UN Charter, Articles 1 (3) and 55.

In order to address these problems, Messer (1997) argues for a pluralist approach to human rights, based on points of agreement between four major sources of modern human rights - western political liberalism, socialism and social welfare principles, cross-cultural rights traditions, and the UN instruments. The necessity for an agreement is due to the fact that Western nations tend to focus on civil-political rights but not social or economic rights; and socialist countries focus on social, economic, and cultural rights but not political rights. Yet all of these rights are interconnected. For example, in Latin America, advocates of the human right to health tie economic and social rights abuses (measured by excess mortality) to civil and political rights violations analogous to apartheid (Heggenhougen, 1995).

Under the UNDHR, protection is accorded to individuals. This reasoning is compatible with the ideals of a liberal democracy such as that found in Canada; however, ironically enough, as many scholars such as Charles Taylor (1994) have argued, in order to treat an individual as an equal, often you must acknowledge his or her membership in a certain group or as a part of a 'collective'; that is, we are all made up of our own individual models of reality, which operate in the broader context of the world around us, and include any groups that we associate ourselves with or use to define who we are, including, but not limited to, nationality, religion, race, and language. For those whose group associations are not the same as those of the majority in a liberal democracy, equality is not possible (see Taylor, 1994).

Of all the accusations hurled at anthropology as a discipline, the most recurring and most talked about has been its past association with colonialization (Asad, 1973; Rosaldo, 1989). According to Karim (1996), the colonial mindset is still, to some degree, a problem in anthropology. Even local anthropologists, she claims, are being used to generate information about human rights, minorities, and the environment for western nations to use as bargaining tools for so-called multilateral economic cooperation. Other anthropologists choose to emphasize an opposing development within contemporary anthropological discourse - that of the role of human rights concerns in anthropology.

The role of anthropology has expanded in recent years to address issues of human rights that were previously not addressed as anthropology attempted to create a so-called non-political discipline (Moore, 1996)[54]. To date, anthropology has served well in this area. Messer (1993) has documented the role anthropology has played in the broadening of the international discourse on human rights; and concludes that anthropology has prevailed in the area of recognizing collective and indigenous rights, and providing details for more specific content for social, economic, and cultural rights. The advocacy for human rights is "by now part of a broader applied anthropology agenda, merged with responsible or engaged anthropology, which contributes to and draws on the human rights framework" (Messer, 1993:237). In fact, the American Anthropological Association (AAA) now has task forces on famine, hunger and food security, AIDS, hunger and homelessness; and a committee on refugee issues (Messer, 1993).

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[54] See also Commission for Human Rights of the AAA, 1993.

International organizations such as the World Health Organization (WHO) now recognize that health is a fundamental, inherent human right. In advocating for the recognition of the universal right to health care, anthropologists are in a good position to inform strategies for supplying this valuable resource by contributing to a global understanding and definition of human rights.

Rappaport (1994) has emphasized the need for anthropology to understand better its relationship with the modern world; therefore anthropology needs to be active within the public sphere, whether it is through participation in policy making or through defending the rights of the peoples being studied. Regardless, anthropology's contribution to policy making and analysis has become increasingly valued in recent years (Puntenney, 1996). This development is further evidenced by the establishment of the Society for Applied Anthropology (SFAA) in 1941, and the more recent establishment of the National Association for the Practice of Anthropology (NAPA) as a unit of the AAA in 1983. Both organizations emphasize the active role of anthropologists in policy making and as proponents of the rights of the groups they study (Bennett, 1996).

The most important debate currently occurring within the anthropological literature in terms of human rights is the relevance of the concept of cultural relativism in applying the United Nations Declaration of Human Rights (UNDHR) (Cohen, 1989). In the Fall 1997 issue of the *Journal of Anthropological Research,* a number of anthropologists debate the relevance of the cultural relativist stance as it is used today within the arena of international politics; namely, the local employment of the UNDHR. This volume is the result of the work presented at an invited session called 'Human Rights: Cultural Relativism versus Universalism' presented at the AAA in November 1995. The arguments presented range from Zechenter's (1997) claim that universalism has worldwide validity, to Hatch's (1997) claim that cultural relativism is still a valuable and useful tool within anthropological research, to Nagengast's (1997) more moderate claim that there needs to be a bridge between individual and collective rights and public and private spaces, arguing for what she calls a 'culturally mediated universalism.'

However, there are a growing number of anthropologists offering a valuable critique of the theoretical implications of cultural relativism, as advocates of universal human rights. The most recent advocates of universal human rights comes from the capabilities theorists, who look at the quality of life of various groups and individuals, and ask whether individuals live as decent a life as they are capable of living (e.g., Sen, 1993). The focus of this theory is on the question of what it means to be human. Capabilities theorists look for commonalities among cultures, religions, and philosophical traditions as well as commonalities among all men and women; and use these commonalities to argue that all individuals must have at least some rights, as they are necessary for human functioning (Nussbaum, 1993). Feminist theorists argue that there are systematic imbalances of power that marginalize certain groups, and that these groups are not included in the cultural relativists' analyses (e.g., Gordon, 1993). Furthermore, Gellner (1985) claims that there is no culture that is so different that we cannot have it communicated to us through some medium, as people can and do successfully adapt to other cultures; and that evolutionary psychology, sociobiology, primatology, psychiatry, modern cognitive sciences, and the neurosciences demonstrate that there is indeed such a thing as a universal human nature. Therefore, by implication, there must also be an underlying universal human unity that allows us to devise a minimum universal standard applicable to all human beings regardless of culture (see also Barkow et al., 1992).

All of these critiques maintain that cultural relativism is contradictory; and based on an idea that culture is static, while marginalizing non-dominant voices or those without adequate agency. Ultimately, cultural relativism in its normative or epistemological form forces us to abandon any meaningful discussion of the diversity within other cultures (Zechenter, 1997). It is ironic that the cultural-relativist defence of certain practices, for example *sati* (more commonly known as widow-burning), has the detrimental effect of ignoring the plurality and diversity of traditions within Indian society, in favour of adopting one view as representative of Indian culture. Therefore, the question remains: why are the less popular views in a culture not viewed as being worthy of protection?

This is not to say that cultural relativism should be rejected entirely. Cultural relativism has taught anthropologists to be open to the multitude of diversity existing in this world, and to not judge these differences according to our own moral stance. But to say that no valid judgments across cultural boundaries can ever be made, or to refuse to recognize the plurality that exists within defined geographical boundaries, is clearly irresponsible, as the logical conclusion of such an argument can justify even such heinous acts as those performed by the Nazis in Germany. This realization is not new; in fact Kluckhohn (1955:266) argued this very point in response to Benedict's claim that all patterns of life are equally valued. The problem remains that while cultural relativism has been exposed for all its shortcomings, we have no moral theory with which to replace it. Perhaps the most effective solution is suggested by Hatch (1997:371), who proposes that we use cultural relativism as a 'default mode of thought,' meaning that it should "govern our moral position in the absence of a persuasive argument to the contrary." However, in encountering each new situation, it is always important that anthropologists remain intensely critical about making moral judgments. It makes no sense to argue, as Roy D'Andrade (1995:408) has done, that morals are unknowable and therefore outside the scope of science.

Globalization and Anthropology

Over a century ago, the task of anthropology, as defined by William McGee, was "to bring order out of that vast chaos of action and thought which has so long resisted analysis and synthesis."[55] Today this task has become even more the central and foremost focus of anthropology. For example, the 1997 AAA annual meetings addressed the theme "The Known, Unknown, and Unknowable in Anthropology," one of the main issues being how closer contact and increasing interaction with more unknowns through the process of globalization is affecting the discipline of anthropology. CASCA's theme for 1998 was "The New World Disorder" and how it affects local culture, as well as the anthropologists who study this new form of culture. In the last several decades, anthropology has struggled to develop theoretical models to study cultures within the process of rapid culture change (McGlynn and Tuden, 1991; Rabinow, 1991). Rapid culture change is generally understood to be the result of communities' increasing contact with other cultures and societies.

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[55] McGee, W. AA1, 1897, pg. 271, quoted in Anthropology Newsletter Sept. 1997, pg. 1.

World systems theory as developed by Immanuel Wallerstein (1974), is based on a Marxist understanding of political relationships between the haves and the have-nots; but shifts the focus from production to distribution. World Systems theory is focused on structural relations, and has emphasized how local cultures become more or less radically reconstructed in ideological or practical adaptive response to the imposition of new frameworks of power and material production. However, world systems theory as an analytical tool within anthropology has for the most part been replaced by what is increasingly referred to as *globalization theory* in contemporary discussions on the relationships between communities, nations, and individuals. In Eric Wolf's *Europe and The People Without History* (1982), globalization and international policies are examined as to how they affect individuals and communities at the local level. Globalization theory has traditionally emphasized a growing interconnectedness and growing homogeneity (see Friedman, 1994).

Nagengast and Turner (1997) identify two camps in which globalization is viewed at the local level. The first camp holds the view that the export of western ideas is a form of cultural imperialism that will erase cultural specificity and increase homogeneity at a global level. The second camp identifies globalization and westernization as two different processes; and points out that globalization has in fact started many local and regional assertions of identity, and therefore acts to increase cultural diversity (see Appadurai, 1997). In William Loker's (1999) edited volume, the effects of globalization on various communities throughout Latin America are discussed and analyzed in terms of the relative benefits and costs to specific local populations, essentially illustrating the distinctions made by Nagengast and Turner. For example, in the chapter by Young and Bort it is argued that globalization has led to more politically engaged leadership among the Ngobe indigenous peoples of Panama, with new social movements and NGOs gaining force and power. Likewise in McDonald's chapter it is argued that local institutions of small-scale dairy farmers in rural Mexico have been reinforced rather than weakened through the process of globalization. However, Vargas' chapter documents how globalization has led to new forms of economic production that have undermined some Latin American communities. Overall, this book is an excellent challenge to unilinear theories of globalization and culture change, providing a description of the complexity and dynamic nature of local responses to globalization in Latin America and the Caribbean.

More recently, Wendy James (1995) in her edited book, *The Pursuit of Certainty: Religious and Cultural Formulations*, has identified a third camp which takes Nagengast and Turner's second point further.

According to James' view, the resurgence of local identity takes a more dynamic and complete form at the level of the individual. Cultural and religious belief systems are now more than ever fuelled by the resources of the richer countries, bypassing the gatekeepers of national sovereignty and of community to make their claim on individual persons. As stated by James (1995:5):

> Exchanges of 'knowledge' or 'belief' used to be multiple, provisional, partial, set within a context of social relations; it was rare for the tokens of ideological exchange to correspond to the whole of a person's being, a commitment demanded by some of the new merchants of faith. Older forms of faith incorporated or at least gave space to doubt and mystery; now we have a commoditized form which offers guarantees.

She therefore argues that religious and cultural truth claims are now potentially disembedded, as they are claiming the freedom to seek an absolute form in an asocial world arena. For example, Werbner (1995), in the same volume, shows how in northwestern Pakistan a Sufi saint's ideas carry an intellectual intensity and produce an emotional commitment among his individual followers miles away in Birmingham and Manchester. Likewise, Shamsul's (1995) chapter describes the 'modernizing' of political and educational processes which produced a generation of Malaysian students who adopt fundamentalist Islam.

Many factors characteristic of the late twentieth and twenty-first century further influence the effects and responses to globalization at the individual and community level. Appadurai (1997) emphasizes the growth of international mass migration and the electronic mass media on national identities, ideologies, and institutions, which he argues are ultimately weakened but provide new opportunities for cultural freedom and expression; and can lead to new forms of justice in post-national public spheres. Kottack (1996) argues that in any study of social and cultural change, the increasing spread of television and the mass media must be taken into account.

Such situations create problems in thinking of culture or at least of a 'shared culture,' because if shared culture (as defined by Wallace, 1961) is viewed as a set of shared rules for accepted behavior in which diverse individuals can function and operate within society, then we must now also contend with the problem of which society is involved? With the delocalization of a shared meaning and behavioral system, rules for conduct would have to be renegotiated on a much larger scale. Thus the dissemination or deterritorialization of the political and ideological base of religious and cultural 'certainties' has created a crisis of sovereignty within the contemporary nation, as to how groups with an increasing number of individuals adopting alternative religious or cultural 'certainties' organize themselves within a shared geographical boundary.

Globalization and Health Care

Hannerz (1992b) states that there are three main tendencies in the formation of personal networks - encapsulation, segregativity, and integrativity. Encapsulation involves people who remain within networks that are largely the same, or have closely related meanings and meaningful forms that reach them through all relationships. These relationships, in turn, play their part in keeping these meanings and forms in continued circulation. To illustrate this point in terms of health care provision, biomedicine at the international level can be defined as encapsulation. Through the use of propaganda, and the political and economic power international agencies hold in creating international policies, industrialized nations are able to perpetuate their beliefs and value systems throughout the world.

In contrast, there are those whose networks put them in touch with various quite divergent cultural sets - not least through their long-distance relationships, and the response to these interactions. These are manifest in various forms of segregativity and integrativity. At the local level, where communities have to respond to international policies, various forms of segregativity (attempts to keep these networks separate) and more often integrativity (those who try to integrate these networks through a syncretism of biomedicine and other forms of culturally-defined medical practices, beliefs, and knowledge) operate. And so it can logically be argued that culture at the local level directly shapes the manifestation of international health care policies in unique and specific ways, as any network on which we focus attention does belong to something wider yet. Geertz (1995:39) shares this view, stating that:

> All politics is quarrel, and power is the ordering such quarrel sorts out: that much is general. What is not general is the nature of the quarrel or the shape of the ordering.

Probably the most recent and far-reaching policy of the WHO to date has been the promotion of primary health care (PHC) programs as an essential and necessary prerequisite to achieving 'health for all.' According to the WHO, a PHC system should provide the following to the entire population: a) universal coverage; b) relevant, acceptable, affordable, and effective services; c) a spectrum of comprehensive services that provide for primary, secondary, and tertiary care and prevention; d) active community involvement in planning and delivery of services; and e) integration of health services with development activities to ensure that complete nutritional, educational, occupational, environmental, and safe housing needs are met (Bryant, 1984). However, as pointed out by Linda Stone (1992), PHC programs are implemented in order to encourage community participation and assist local communities to define their own needs (point d above). Yet WHO has already set its own parameters around both the needs of the people and the range of possible means of meeting them; and therefore is contradicting its own grassroots approach, because in order to have real community participation, communities must also be involved in the decision-making process. Furthermore, community participation, as a concept in itself, is consistent with the principles of equality and self-reliance that the philosophy of international health care promoters espouse.

Morgan (1990) has shown how one country, Costa Rica, has exemplified the principles of the 1978 Alma Ata declaration on primary health care, except that it has not met point d, community participation. Morgan argues that it is important that the historical, economic, and political context of a country be considered in trying to understand its primary health care policies. Costa Rica has no history of community participation in health care services, and has experienced a long history of compliance and dependence on services that was encouraged during its development. Even between the years 1978 and 1982, after Alma Ata declared that community participation was integral to the development of primary health care, people generally participated out of compliance (Morgan, 1990).

Globalization not only transforms economic goals but also economic resources, and therefore transforms political organization and ideology (Orlove, 1998). Kamat (1995) demonstrates how PHC functions in the context of a growing demand for western drugs. In her study of a rural health care practitioner in India, she found that local people do not believe that there is any local consultation or participation in PHC initiatives. Within the context of one physician's medical practice in India, western 'special' medicines were offered only to paying patients because shortages made them unavailable to everyone. The practitioner in question claimed that this practice allowed him to provide western drugs to the most needy. In effect, this practice implied to the general population that

Ayurvedic medicines were inferior to western biomedical drugs; and as an increasing number of people began to view western medicines as necessary, they became resentful that only the rich could have them. Gessler (1994) further points out that there is a barrage of problems associated with the control, dissemination, and cost of pharmaceutical drugs worldwide. One problem is that doctors and pharmacists, creating the false impression that they are more effective, promote brand-name drugs worldwide over cheaper generic brands. Furthermore, while in 1994 there were over 30,000 drugs available on the international market, only between fifty and sixty drugs are needed to treat eighty percent of a country's health problems. Drug imports further demonstrate the favouring of the wealthy and their health care needs over the general population. For example, in North Yemen only 1.3 percent of drug imports were to treat its three most prevalent diseases (Gessler, 1994).

Dependency on foreign aid programs has resulted in many problems in terms of the preservation and self-sufficiency of traditional health care practices. For example, Lewis (1993), in his work in the West Sepik Province of Papua New Guinea, has seen that many western treatments have replaced traditional treatments for leprosy; for example, Band-Aids have replaced traditional leaf and bark wrappings. This process has resulted in a loss of control over the supply of materials used to treat leprosy; and availability, distance, cost, and distribution are beginning to determine whether someone receives treatment (Lewis, 1993:205). Since there is no end to the demand for resources for the treatment of illnesses, little room is left for health promotion and prevention, further reinforcing the dominance of high-tech diagnostic procedures and hospital-based surgical and pharmaceutical treatments characteristic of biomedical practices at the expense of cheaper and more holistic approaches to health, which in most countries are more appropriate. A more accurate and culturally relevant approach would view the *quality* of health as important in determining levels of health care provision.

The World Health Organization's Mass Childhood Immunization (MCI) project is a perfect example of how conflict can arise between the broader local and international cultural frameworks. The WHO's efforts to eradicate smallpox worldwide was a very successful program, as this disease that once killed millions of people has now virtually vanished from the face of the earth. However, due to the success of the smallpox immunization program, the WHO now unconditionally supports MCI - which is a classical vertical or top-down health policy.

In most places in the world, general practitioners, public health nurses, and health visitors are the mediators and executors of government policy on child immunization. Recently these health care workers have been subjected to new forms of political influence, namely the policy of reaching a 95% immunization rate, with financial incentives for meeting these targets (Pilgrim and Rogers, 1995). This program creates many problems when translated at the local level. One problem is the conflict between individual vs. communal rights. For example, a crude reliance on MCI obscures the wider political determinants of ill health such as poverty and unsuitable access to proper sanitation. In fact, social class, even in Western Europe, has been shown to be a better indicator of contraction rates of disease than immunization status (Pilgrim and Rogers, 1995). Likewise, victims of individual long-term health concerns, such as iatrogenic problems for the immune system that sometimes occur with vaccination (i.e., auto-immune disorders and some cancers), and vaccine failure which can cause anaphylaxia, encephalitis, and arthritis, in most countries are not compensated or cared for, thus placing the burden on the family.

Furthermore, international policies on MCI are criticized as providing local governments with propaganda and not true information on the effects of immunization (Lafond, 1995). Many issues arise from this practice, such as the role played by informed consent. In the current case, whereever financial inducements are given to general practitioners for reaching WHO immunization levels, questions arise regarding the suppression of the right to parental dissent, as some families who choose not to immunize their children are removed from lists, forced, or coerced into having their children immunized. This practice is demonstrated in a study conducted by Lafond (1995) in Somalia. Because it was believed that only Allah could determine if a child would become sick, immunization made no sense. Furthermore, there was a great deal of mistrust directed toward the Ministry of Health and its doctors, because they were perceived as being unsympathetic and poorly staffed. This mistrust resulted in a number of misconceptions surrounding the immunization campaign (i.e., many women believed that the vaccines would make them sterile). Lafond (1995) concludes that if modern medicine is to be credible to people, it must improve curative services of local clinics and mother/child health centres; and that all future health programs should be based on prevailing notions of disease prevention, with the input of traditional healers; and on education rather than forced compliance.

Another problem with MCI and other mass immunization campaigns has been raised by Nichter (1995), who questions the sustainability of immunization campaigns with increasing cutbacks to health care expenditures. He also explores such issues surrounding the acceptance and rejection of immunization campaigns; and suspects that as disease rates fall, there will be less demand for immunization because the direct threat is not as prevalent or obvious.

From existing accounts, it is evident that technological developments in vaccine programs are deeply influenced by the beliefs and values of biomedical researchers and health program administrators, who regularly deny that they themselves possess 'culture'. And yet, as maintained by Greenough (1995:606): "the desire to control or eradicate diseases by delivering the fruits of immunology to the world constitutes a markedly cultural feature of modern bio-science and medicine."

In terms of cross-cultural comparisons of health care systems, the manifestation of biomedical culture at the local level, even when compared across societies of equivalent wealth and similar commitment to biomedical research and technology, such as Japan, the United States, and Italy, still exhibits considerable variation in defining competent doctoring, as well as in practice patterns and standards of clinical care (DelVecchio-Good, 1995:461-462). One way this variation is manifested is through the discourse between doctor and patient. For example, in Canada and the United States, as a part of the doctor-patient discourse, the physician provides explicit diagnosis of illness and an array of 'treatments'; this practice affirms the patient's right to know and to decide among treatment options. In Japan and Italy, however, physician-patient relationships are described as paternalistic and protective; and involving the masking of diagnosis through an ambiguity in discussion of prognoses and treatments - especially for cancer patients (Good *et al.*, 1992; Gordon, 1990); this is due to the fact that a form of 'social death' results from the knowledge of terminal illnesses. As a result, both Japan and Italy have traditionally refrained from using the high-tech biomedical treatments for cancer widely employed in North America and the rest of Europe, as they are often toxic and intrusive, and therefore make it difficult to hide the fact that one has cancer. It is believed that 'hope' plays an important part in cancer treatment, outweighing the benefits of high-tech biomedical treatments. This practice has recently led to much criticism of the traditional ways that Italy and Japan deal with cancer patients, as it is believed at the international level that the more radical methods of treatment are more effective in treating cancer. Therefore both Japan and Italy are reconsidering the way they treat cancer patients (DelVecchio-Good, 1995).

The example of Japan and Italy demonstrates how even in countries of relative wealth and power, international models of health care prevail over cultural interpretations of health care practices. In countries in which such wealth and power is not as predominant the situation would be further confounded. This situation is especially true considering the fact that the World Bank reported in 1993 that between twenty and fifty percent of health care aid in most developing nations is provided by international agencies. Furthermore, many health leaders from developing countries have proposed a new world federation that would work to create the conditions necessary to achieve more equitable world health (Bryant, 1980). It is therefore important that any dialogue on contemporary health care practices integrate discussions of both political economy and culture (that of the 'other' and that of 'biomedicine').

Conclusion

Various attempts have been made to create an official pluralistic health care system throughout the world. For example, Zimbabwe has organized joint seminars, publication of a register of traditional medical practitioners, and some forms of self-regulation (Hyna and Ramesh, 1994). However, the WHO (1983) has no single universally accepted concept of integration; and many countries have yet to clarify it in their public policies, although it is obvious that a certain ideology prevails. This particular ideology is enforced through economic and political pressures applied upon countries that stretch the limits of acceptable health care practices. Many problems arise when countries try to exert their own particular forms of health care beliefs, as they are often left unable to defend their right to practice health care in a way that does not meet with implied and enforced ideologies of the WHO. In fact, Keane (1998) suggests that the real focus of any study on world health should be on the 'global structure of difference.' The next chapter illustrates how Cuba has positioned itself within such a structure.

Chapter 4: Cuba's "Official" Views on Medical Pluralism

In this chapter I outline a history of Cuba's post-revolutionary health care system, discuss Cuba's current 'official' position on health care pluralism, and attempt to position Cuba's health care system within the global sphere of influence outlined in the previous chapter and developed here. The official interpretations and implementations of medical pluralism form the localized organizational structure of the framework that is being developed in this thesis. However, it is important to keep in mind (and this thesis will later show) that the 'official' word on health care pluralism, like anything else, is interpreted, acted, and experienced differently in the real world than it is in stated policy.

A History of the Development of Cuba's Post-Revolutionary Health Care System

It was immediately following the 1959 revolution that Cuba announced its plans to become a 'medical power' capable of providing the expertise and technological transfer that Latin America and other developing countries might need. These plans were initiated by a ten year period (1959 to 1969) that focused on the curing of infectious diseases which at the time claimed thousands of Cuban lives every year, particularly those living in rural areas (Ruffin, 1990); and the development of a coherent network of services that would later become the infrastructure of a comprehensive, unified health care system. Resources at this time were devoted to maternal-child health and control of infectious diseases through national disease-specific programs and campaigns co-ordinated with services at the local level that were targeted at specific health problems and under-served areas (Santana, 1987; Minkowski, 1973). By the late 1960s health services had been consolidated into a single system (Santana, 1987).

The years from 1970 to 1974 were characterised by increasingly coherent and better-organised services, new programs in maternal-child health with special emphasis on the development of primary care centres, and improved information and statistical control (Santana, 1987). During this time mortality and morbidity rates dropped and life expectancy rose; but the system remained hospital-centred, with uneven regionalization.

In 1974, the system of *medicina en la comunidad* was first introduced into the Cuban medical system. By the 1980s, the medical community base expanded to include mini- polyclinics, which made the doctor responsible for assuming the health and care of his or her community. At this time the most prominent diseases were of the sort that kill at a later age (i.e., cancer and stroke) and cannot be cured with quick low-technology treatments. 'Medicine in the Community' therefore became more focused on preventative medicine (Santana, 1987; Diaz-Briquets, 1983). Preventative medicine in Cuba includes widespread education about the dangers of various health conditions (e.g., smoking, care during pregnancy, obesity, etc.), the importance of a clean environment (which emphasizes both the care and respect of the environment), health inspections, and large-scale disease-prevention programs. In accordance with the policies of 'Medicine in the Community,' health care teams emphasize the interrelationships between the wellness of individuals, families, and communities (Iatridis, 1990).

During the 1980s, the medical system was redesigned for complete regional coverage. Projects involving massive decentralisation were implemented; and primary care services were available from four specialists: dentists, internists, paediatricians, and obstetrician-gynaecologists (Santana, 1987). Furthermore, by 1985 the 'Medicine in the Community' model had been installed with the following goals realised:

> 1. Preventative and curative services were integrated.
> 2. The polyclinic was given responsibility for the total health of a defined geographical area and population.
> 3. Primary care services were co-ordinated with secondary and tertiary levels of care.
> 4. Continuity of services by the same staff was to be assured.
> 5. Strict follow-ups of high-risk patients and the chronically ill were required.
> 6. Specialists practice within the framework of the health team.
> 7. Services had to include active community participation, especially in health education (Santana, 1987: 114-116).

In the early 1980s *El Ministerio de la Salud Pública* (MINSAP) reformed the medical education curriculum because of the high incidences of noncommunicable diseases then present in Cuba. The reform strategies aimed at placing increased emphasis on preventative and primary care, creating a primary care "specialty" and providing a broad-based interdisciplinary approach to primary care training (Cardelle, 1994). In 1984 the government initiated the program of *Medicina General Integral*. In this program, before a doctor decides on a generalist versus specialist career, all residents receive three years of training in family medicine. This training includes rotations in each primary care specialty (internal medicine, pediatrics, and obstetrics and gynecology), as well as longitudinal continuity experience based in a local neighbourhood and supervised by family physicians. Doctors may then decide if they wish to remain a *médico de la familia* or to specialize in one area of medicine (Waitzkin et al., 1997).

A *médico de la familia* in Cuba will often live above their *consultorio,* where they hold their office hours every weekday morning. Individuals who live in this area will come by for a *consultorio;* but if they need to see the doctor outside of office hours, it is not uncommon to call or show up at the doctor's home during the afternoon, evenings, or weekends. Afternoons are generally spent checking up on patients within the doctor's designated area who have special health needs or who require follow-up care. According to MINSAP's *Carpeta Metodológica*[56] *1999-2000*, patients are classified into four main categories: Group I are individuals that after having been examined by the doctor are reported to be in good health; Group II are those considered to be at risk of developing illness or disease (e.g. smokers, the obese, etc.); Group III are those who have been diagnosed with a certain disease or illness (e.g. diabetes); and Group IV are those with an illness or who have had an accident that has resulted in some sort of alteration in their normal motor, functional, sensorial, and/or psychological functioning. Each of these four groups are further divided into age categories, and each then have their own schedule for the number of visits they will receive at home and that they will need to make to their own *médico de la familia*. For example, a healthy adolescent or adult will receive one annual visit and be required to make one annual visit to their family doctor, whereas an ill adolescent (Group III) will visit the doctor every four months and will continue to be visited at home once a year. Other classifications made by the family doctor include defining individual families as functional or dysfunctional, and sorting individuals according to stress levels experienced as a result of work or other sources.

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[56] Methodological File.

Under this system, it is expected that all patients in the catchment area receive preventative services appropriate for their age, gender, and risk factors. Records are maintained on all patients, and in theory are to be updated and reviewed monthly under the guidance of a clinical supervisor. In a study conducted by Waitzkin et al. (1997), they found that the family doctors they observed were knowledgeable and maintained surveillance records regarding all patients for whom they were responsible. They found this surveillance system to be hooked up electronically at all provincial levels, and currently being extended to municipalities and rural health centres. This system is used to clarify rapidly such problems as the spread of infectious diseases, the changing distribution of chronic diseases, and unusual clinical conditions such as the neuropathy epidemic in 1991-1993.

Today MINSAP states that primary level health care (which includes the *médico de la familia* and the 440 policlinics) in Cuba should deal with approximately 80 percent of all individuals' health problems. According to statistics gathered by Garfield and Santana (1997), the medicine in the family program now covers more than 90 percent of the Cuban population; and the American Association for World Health (1997) reports that more than 95 percent of the population is served by family doctors living in the communities that they serve. All medical services in Cuba are performed free of charge (including cosmetic surgeries), and most prescribed medicines (if available) can be purchased at a minimal cost to the patient or free of charge if the patient is a social services recipient.

The post-revolutionary Cuban government has an official policy of encouraging members from all ethnic groups, formerly lower-class individuals and women, to enter medical school. Medical education in Cuba is provided free of charge to all students, making it easier for individuals from all social categories to access. Currently 48 percent of physicians and 61 percent of family doctors in Cuba are women (Waitzkin et al., 1997).

Cuba also has very well developed secondary and tertiary health care levels. There are 284 hospitals in Cuba that provide emergency and surgical services, as well as eleven national institutes providing high-technology, specialized care. Cuba is the world's second largest producer of the Hepatitis B vaccine, and has developed the best available vaccine for viral meningitis. In 1990 the Centre for Molecular Immunology opened in Havana, and is used to develop potential treatments to fight cancer (Waitzkin et al., 1997). This work has received the attention of Toronto-based York Medical, which invested over eight million dollars in the centre in exchange for patents and marketing rights on all products developed. Furthermore, Cuba is currently undergoing human testing for an HIV vaccine developed at the Centre for Genetic Engineering and Biotechnology that opened in 1986. Cuba also has the capacity and the scientific know-how to perform numerous complex transplant surgeries (Waitzkin et al., 1997).

Today, Cuba's health care system, in terms of internationally recognized health care indicators, resembles that of any Euro-American health care system (see Table I for a comparison of Cuba and Canada's social indicators). Life expectancy, one of the primary indicators used to measure the success of any health care system, had reached 73.5 by 1982, up from 57 in 1958, a gain of 16.5 years (Danielson, 1985); the doctor-patient ratio is the highest in the developing world and one of the highest in the world overall; and the percentage of children in school is one of the highest anywhere (Morris, 1996). However, there were some easily identifiable differences, namely a broad-based community approach to health and health care, the role of mass organisations in the provision of health care; and in some cases, a greater distribution of health resources (Iatridis, 1990). Preparation of nurses to do community work is universal. In contrast to countries such as the US where community nurses receive additional training and field work in community health, all nurses in Cuba receive course work in public health, epidemiology, and bio-statistics, and field work in polyclinics in their base 3-year nursing preparation. Beginning in 1977, an additional university level program was offered, called *licenciatura en enfermeria* to offer additional preparation in administration, teaching, and research (Swanson, 1988).

Cuba's Position on Health Care Pluralism

At the commencement of Cuba's Special Period, the Cuban government was quick to realize that, given the current state of the economy, it was no longer in a position to provide the expensive, high-tech care that Cuban patients had formerly become accustomed to. As a result, the government decided to introduce certain measures that would facilitate the introduction of traditional and alternative forms of health care delivery into the official biomedical system of medicine.

In 1992 Cuba introduced its most comprehensive policy on traditional and alternative medicine, in what is called Resolution 9.

According to Marta Perez, the Director for Traditional and Natural Medicine for the province of Havana, Resolution 9 is a document that outlines which forms of traditional and alternative medicine are permitted to be practiced in Cuba's official health care system. She stated that there are five groupings of traditional and natural medicine included in Resolution 9. They are:

Medicina verde (green medicine or herbal medicines). This category includes all herbal medicines that have been determined by MINSAP researchers to be safe and effective in the treatment of various illnesses, and currently includes a list of over 50 different herbal remedies.[57] In addition to herbal remedies, this category includes bee products and all derivatives of such products.

Acupuncture. This category also includes related therapies such as massage, moxibustion, electromagnetic therapy, photopuncture, digital-puncture, laser- acupuncture, and acupressure.

Homeopathy. This category includes all homeopathic and Bach Flower remedies.

Thermotherapy. This category includes mineral muds, radium water, sulphur baths, hot/cold water therapies; and the production of various soaps and other cosmetic products produced from various mineral muds, radium, and sea water.

Hypnosis and suggestion. This category includes the use of guided imagery, various hypnosis techniques, and biofeedback.

Perez said that she felt that the most successful of the new techniques is acupuncture, which is used to replace expensive and hard-to-come-by anesthetics; and certain homeopathic remedies for tooth extractions.

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[57] Personal communication with Leoncio Padron, Director of Traditional and Natural Medicine for MINSAP, February 22, 1999.

As mentioned, Resolution 9 outlines which forms of alternative practices are accepted; however, Perez informed me that this did not mean that these categories are in any way exclusive:

> Adding these things to a health care system which was completely allopathic was very hard, and we defended it by saying that they provided a wider range to treat various ailments. We are looking for those with a strong scientific basis. For example, the laying on of hands cannot be standardized and the scientific basis cannot be measured, so how do you do this in a hospital? It is not prohibited, however; and it is good for the doctors who use it to create a knowledge base of who it works with and who it doesn't so we can learn more about it.

Likewise, Leoncio Padron, the National Director of Traditional and Natural Medicine, said:

> It is not a matter of rejection; it is a matter of many of them still being in the research phase. We need to find out what the priorities are. There is a Spanish phrase that says, if you want to have too much, and then you will get very little. There are hundreds of therapies in the world of traditional medicine; and we think that in order to know everything about these therapies, it must be a gradual process; and the things that are not yet proven should not be used on people until they are proven. Traditional Chinese medicine like acupuncture, digital acupuncture, moxibustion, traditional Chinese exercises like Tai Qi, massage - in reality these are very effective therapies. We accept these.

And another MINSAP worker at the municipal level has the following to say:

> *Are there regulations for the practice of traditional medicine in Cuba?*
>
> Well, at the beginning when the use of traditional medicine commenced, everyone that was passionate or interested in using it and who had some knowledge of it, used it. But

> some people, since they did not have all the required knowledge, since they began to use it...
>
> *And so are there any regulations?*
>
> I think that now, yes, they are making some regulations to demand that for the personnel, for the doctor, for the technician, the nurse that uses some of the techniques of traditional medicine, to ensure that they have the capacity for this. Because in this moment there exists people that do not have all the knowledge for this, that think that because they have read a pamphlet they already have the ability to use it, and so they may cause harm. The specialization was developed because these people did not have all the knowledge; and so when they used it, they gave it a mystical component, without a scientific basis; and instead of getting better and giving it the value that it truly has as a specialty, they would cause harm. Now patients receive it from the person who really has a specialty; now there are regulations that one has to be a person who is technically very skilled.

The introduction of Resolution 9 also brought about several changes to the medical school curriculum. For example, under the new curriculum, all doctors must rotate through clinics that specialize in natural and traditional therapies in the last two years of their six years of study. Acupuncture has also been incorporated into conventional medical courses. For example, in physiology and anatomy classes, the positions of the various meridians and acupuncture points are taught in addition to the standard teachings on bone, muscle, and other physiological and anatomical positions and functions. Furthermore, medical students since 1996 are required to treat three uncomplicated cases successfully with acupuncture in order to graduate.

While it is believed that the new medical curriculum provides all doctors with the basic principles of acupuncture, doctors wishing to receive more advanced training in acupuncture or other forms of traditional and alternative health care practices can take courses following their six years of required general medical training. These courses take various forms, and result in various levels of proficiency in acupuncture and other alternative medical techniques. For example, doctors may take a two-month course focusing on the basic principles, or a one-year diploma course that teaches the more solid elements of acupuncture. Doctors may also choose to do what is called a specialization in traditional and natural medicine. The specialization is an additional four years after medical school, and covers all the techniques outlined in Resolution 9. There is also a Masters in traditional and natural medicine available that is a thesis-based course, and takes approximately two years to complete.

In addition to these more formal methods of instruction, doctors and other health care staff may take general interest courses in traditional and alternative techniques that are made available at various clinics. While I was in Cuba, I took one such course at the clinic where I was doing the majority of my participant observation. The course was once a week for two hours for two months; and dealt with the basic philosophy of acupuncture, homeopathy, mud therapy, hypnosis, Bach flower, and herbal medicines. Most of the people in the course were nurses or technicians; and the classes had a definite informal feel, with many people interrupting to ask questions. There also were several instructional tours of the clinic's various departments. What impressed me the most about the class was that the instructor did in fact address many of the philosophical underpinnings of many of the techniques being used at the clinic. For example, during the acupuncture section we learned about the five elements and their corresponding organs, temperatures, colours, times of day; and their relationships to each other, Q'I, and Yin/Yang energies. MINSAP and other levels of the public health ministries encourage all clinics to send at least one person to such courses, or to hold courses themselves, in the hopes that every clinic will have at least one doctor and several staff who are well versed in the various techniques of traditional and alternative medicine.

Before I had officially begun my study in Havana, I believed that the use of traditional or alternative medicine in Cuba was officially prohibited (see Pederson and Barufatti, 1989); but I quickly found that this was not the case. Biomedicine was certainly the dominant form of medical practice. However, some research had begun in the area of traditional and alternative medicine long before the commencement of the Special Period. Furthermore, the use of popular home remedies continued to be used after the revolution; and never became an issue. One government official gave me the following account of how acupuncture was introduced in Cuba:

That is the official message – Resolution 9. It was, I think in 94 or 95; but acupuncture was introduced in Cuba by 1962 by an Argentine doctor named Floreal Carballo,[58] and there is a booklet published by him. He was from the group of Argentine doctors that came to Cuba to help Cuba when the US government developed propaganda in order that the doctors in Cuba would leave the country, and we had more than 3000 doctors who went away. And then a group of doctors from Argentina and Mexico came to help us, and in that group came Floreal Carballo. The first Cuban that learned acupuncture was an ophthalmologist, the same as Floreal Carballo. Even before, in February of 1938, a medical doctor of the general and chief of the liberation army, Maximo Gomez, in a conference about pre-Hippocratic medicine, spoke about the Chinese medicine; and told the doctors that they should study and look deeply into it; and that is, as far as I know, the most ancient reference to that. What happened is that in the last five or six years we had, well, from ten years ago now we had a catalyst which sped up what was being developed very slowly; but you cannot develop a medical specialty in four years if you don't have many years of work before. You cannot. What happened was when the economic crisis came, it acted as a catalyst and made the people think more and more about how to develop these things faster and better in order to substitute for what we did not have. That was the catalyst for the administrative, people in charge of administration in the Ministry of Public Health. Up until that moment they were not so much concerned with this medicine because most of them were educated as allopathic doctors. But those are the historical conditions that the bad things helped to develop certain things. It is not true that it is from ten years ago; it has been a long time before.

So Resolution 9 was just the official support or recognition?

Yes, yes, 1962 – no, no, not official because I was working in acupuncture twenty years ago; and I was not hidden in any place. I worked in hospitals, but it was not recognized as a medical practice and a specialty. But someone was doing something.

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[58] Many doctors whom I interviewed also credited this man with having been the first to bring acupuncture to Cuba.

Another Ministry worker told me that Cuba had already begun to integrate acupuncture by 1970 as part of a Cuba-China medical exchange. In my interviewing of Ministry personnel, there was a general consensus that the reason why acupuncture and other forms of traditional and alternative medicine were being used on such a large scale today was because of the economic need for cheaper, more sustainable forms of health care; but that these alternative forms of health care were being explored anyway; the Special Period just accelerated their official implementation.

Today in Cuba every province and almost all municipalities have a centre for the development of traditional and natural medicine. Traditional medicine is practiced at all levels - primary, secondary, and tertiary; and every hospital, institution, and clinic must have a department of traditional medicine. According to MINSAP statistics, in 1996 300,000 Cubans were treated with traditional medicine; in 1997, 400,000; and in 1998, 3,000,000.[59] In 1995 Cuba produced 35 million bottles of herbal tinctures made available in local pharmacies; in 1996 it produced 48 million; and in 1997 and 1998 it produced 50 million, roughly equal to 4.5 bottles per person.[60] According to Padron, if there were no allopathic medicines available, Cuba would need to produce approximately 15 bottles per person per year. The most common illnesses treated with traditional and natural medicines are respiratory problems, chronic illnesses, osteoporosis, hypertension, asthma, and problems in the joints like arthritis and

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[59] Personal communication with Leoncio Padron, February 22, 1999.

[60] Personal communication with Leoncio Padron, February 22, 1999.

artrosis[61]. In addition, Cuba now performs more than twenty different types of operations using acupuncture in place of expensive and hard-to-get anesthetics, totaling 848 operations in 1996; 4,000 in 1997; and over 7,000 in 1998.[62] According to the *Carpeta Metodológica 1999-2000*, produced by MINSAP, currently 87 per cent of the traditional and natural medicines used in Cuba are also produced in Cuba.

In a recent article by Christopher Keane (1998), it is argued that how a nation views its health care system is a reflection of the larger views of how societies "can and should be structured" (Keane, 1998:226); and that "the existence of widely differing conceptions of world health are largely explained by competing world-oriented ideologies" (Keane, 1998:227). Keane (1998:237) further states that:

> Global analysis of health will continue as processes of globalization and globality continue and remain unavoidable issues and problems. We must examine critically the ideologies that underlie concepts of world health. Just as ideas about health and health care have been shaped by conflicting ideologies such as individualism, socialism, and corporatism (which are responses to the industrial revolution), important *social movements* of the future will very likely be responses to globality and globalization, which will very likely shape how we think about world health (emphasis added).

I will now turn to a discussion of how a radical change in the socio-economic conditions in Cuba (i.e., the 'Special Period') has precipitated a restructuring of health care practice within Cuba which follows the world-wide social trend of developing officially recognized pluralistic health care systems (WHO, 1983). This restructuring has subsequently led to a shift in Cuba's official image of 'world health,' both internally and that which is espoused by Cuba to the international community. This shift has been from Keane's Image II to Image IV. I will outline Keane's typology of world health, and then analyse Cuba's shift in terms of three main points which directly coincide with Keane's Image IV: the transferring and sharing of information across national boundaries, the view that all health care systems share a similar structure and role, and the maintenance of global health standards as set by the World Health Organization (WHO).

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[61] This was a common diagnosis of the patients that I saw at various clinics throughout Havana. It was described to me as being similar to arthritis, only instead of inflammation of the joints; the joints were surrounded by water.

[62] Personal communication with Leoncio Padron, February 22, 1999.

Christopher Keane's Typology of "World Health"

Keane's (1998) typology of the four ideal images of "world health" is based on Robertson's (1991) typology of the four ideal images of world order. These are defined in terms of four points of reference - individuals, society, system of societies, and humankind. Each of these points takes either a community *(gemeinschaft)* or society *(gesellschaft)* orientation. The point of Keane's typology is to explore the social construction of health and illness through their implicit, underlying images of how societies "can or should be structured." However, it is important to point out (as Keane has done) that any typology simply defines a set of ideal types; and in practice any image of world-health would likely include aspects of two or more types. Keane's four images are outlined here:

Table 2: Keane's Typology: Images of World Health

Keane's Type	Description
I. Gemeinschaft I	- community health workers and traditional practitioners are important for a "communal" health system. - health care should be suited to the uniqueness of the society it serves. - traditional medical systems are seen as maintaining physical health and protecting a society's own cultural identity. - the cultivation and protection of a society's system of health- related beliefs is promoted.
II. Gesellschaft II (Cuba prior to the Special Period)	- emphasis is on the system of societies, and reveals world-wide patterns of exploitation. - health and economics are intertwined, and so one nation's health cannot be viewed outside its relationships within the world system. - "world health" would be best obtained through a socialist world government. - views the "different but equal" mind-set (of Image I) as a method of legitimizing low-quality health care for the poor, instead of providing the poor with access to what is considered to be superior modern health care systems.
III. Gemeinschaft II.	- views all of humankind as intertwined and linked through unseen forces. - by providing help in the way of health care provision in one society, one is actually aiding all of humankind. - focusing on individual communities (as in Image I) is viewed as illogical since many illnesses, disease patterns, and epidemics are not self-contained within one society but affect humanity as a whole (e.g., the world-wide AIDS epidemic).
IV. Gesellschaft I (Cuba in the Special Period)	- sees the world as a series of open national societies in which nation states serve as the principal agents of world health - achieving world health requires that all nations have access to all health-related information - health care systems are viewed as sharing certain important characteristics in their structure and in their duty to the health needs of their citizens - the problem of global inequalities between nation states can be solved through the sharing of "generally compatible, universally applicable health technology." - promoted by the WHO, which facilitates exchange of information and ideas between nation-states and sets up codes of (voluntary) national health standards - rejects organizing the world as a system of closed societies, and maintains that all nation states must take some responsibility for the health problems of the global environment.

Traditionally medical anthropology has taken the view of Image I (what Hannerz, 1992a calls the 'cultural mosaic') whereby the world is looked upon as a series of isolated cultural groups that can be studied and compared to others. While this view continues to be predominant within popular discourse, including many health care workers whose projects proceed on this understanding, medical anthropologists now critique this view as being limited in scope, seeing the native as trapped within a bounded traditional medical system (Keane, 1998). Image IV is gaining ground in more recent medical anthropology works, and is the typical view of the critical medical anthropologists. Stanley Yoder (1997) provides a good review of the role of medical anthropologists in various international health care projects; and the challenges they face in trying to implement changes in both projects and the underlying ideologies of health care providers and researchers in various disciplines, including abandoning approaches to local health practices as self-contained and bounded.

The Sharing of Health-Related Information

Cuba has long held the ideology that the best way for a world system to function in the best interests of all people is through a world socialist government, an ideology consistent with Keane's Image II - Global Gesellschaft II. This ideology can be seen as early as the writings of Cuba's own national hero José Martí in the later half of the 1800s and later in the writings of Che Guevera, who in fact died in Bolivia where he had gone, following the Cuban revolution, in an attempt to stage a similar Cuban-style revolution as a part of his dream to transform all of South and Central America into one large socialist state. This ideological stance was manifested in the extensive participation of thousands of Cubans, called *Internationalistas,* who delivered medical, educational, and military aid throughout the developing world. The *Internationalistas* were considered to be performing a great patriotic act, and the delivering of aid was seen as a way for Cuba to bring the benefits of Cuban socialism to the rest of the world (Rosendahl, 1997). Cuba has gained repeated recognition internationally for its role in providing health care services to other developing countries. In 1985 Cuba had more doctors working abroad than the entire WHO - over 1500 medical personnel in 25 different countries (Feinsilver, 1989).[63] Furthermore, Cuba is the only country in the world that trains surplus doctors specifically for export; and trains medical professionals from other countries, often free of charge, provided that following their studies, the students return to their own country to practice medicine (Feinsilver, 1989). However, in 1991 this form of foreign assistance stopped for several years; and is currently greatly curtailed, as it is no longer economically feasible (Feinsilver, 1989).[64]

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[63] Up until 1977 this form of medical aid was provided free of charge to the host country. However, since 1977, countries pay based on what they are able to afford (sometimes nothing). Still, the amount paid to Cuba for doctors is well below the average level paid to doctors from other countries, including Chinese and Russian doctors (Feinsilver, 1989:19-20).

[64] However, shortly after I arrived in Cuba, Hurricane George had devastated several Central American countries. Cuba immediately offered to send doctors to Honduras and Nicaragua.

According to Julie Feinsilver, "Cuba's efforts to become a world medical power can be viewed in part as an exercise in symbolic capital accumulation" (1989:3-4). In her article, she outlines how Cuba has exerted a huge amount of power internationally, which is uncharacteristic of a small developing country. Included in this influence has been Cuba's constant advocacy of Third World rights and interests at international forums; its role in international health care aid; and its influencing of the former Soviet Union's policy on Angola, Nicaragua, and Grenada. Indeed, it was through the urging of the Cuban political leadership that the Soviet Union became involved in these countries' struggles, which indicates that the relationship between Cuba and the former Soviet Union was not as unilateral as is often portrayed.

Cuba has long believed that the sharing of health care information is crucial to the formation of its own status as a 'world medical power'; and has made efforts to this effect ever since the 1959 revolution, despite the fact that by 1964 nearly half of Cuba's 6,300 physicians as well as many nurses had fled Cuba, most to the US (Swanson, 1988). However, until the onset of the Special Period, sharing of health care information between Cuba and the rest of the world took an asymmetrical form, in that Cuba provided generous amounts of medical aid to other poor and developing countries, receiving very little in way of direct economic return. At that time, benefits to the Cuban political system were largely symbolic, in that the policy generated respect and legitimacy for the Cuban regime instead of direct economic payoff.

Nonetheless, in its transition to Image IV - Global Gessellschaft I, Cuba has certainly maintained a healthy position as a provider of health care information and services; only now this position takes a more dynamic form, in that instead of being a net contributor to worldwide health information and aid, Cuba also receives a great deal of health information, education, and aid from the outside community. Doctors from China and Korea in particular were brought to Cuba to teach Cuban doctors about acupuncture and other forms of traditional Chinese and Korean medicine in attempts to replace much of the expensive western-biomedical style treatments that the island could no longer afford. Today Cuba continues to host a number of international conventions on various forms of traditional and alternative health care techniques. Representatives from countries all over the world are invited to come to Cuba to share the advances and techniques that it has made in these areas. When I was leaving Cuba in July 1999, the national homeopathic association was preparing for one such conference, in which homeopathic doctors from around the world were coming to Cuba to share their knowledge and methods of homeopathic practice with Cuban doctors, as well as having Cuban doctors share what they had learned in this area to date. I had the following dialogue with one doctor:

Where did you learn about traditional medicine?

> Well, traditional medicine? I learned it here in Cuba, of course. I learned it here with different professors who came from different regions of the world. I have already told you that I have had professors from Brazil, Mexico, Spain, Italy, the US, and basically... Argentina as well. These people are the ones who educated me with respect to homeopathic medicine. In other medicine, let's say acupuncture for example, that has been mostly with Cuban teachers. These Cuban professors have been taught by Chinese and Korean people, Asian professors, that is.

I was also told that the homeopathic medicine now being used in Cuba began when MINSAP invited many people from different schools of homeopathy to Cuba to present their methods of practice to Cuban doctors. MINSAP then took what they thought were the best elements of each school and created their own school. Leoncio Padron confirmed this report. One professor of traditional and natural medicine for the Cuban army told me that he first learned about medicinal herbs while doing military service[65] in Angola. Herbal medicines and other traditional medical practices were used during this time because they were simple, cheap, and available under wartime conditions. He further stated that a lot of the knowledge Cuba currently uses in the area of herbal medicine was learned in Angola from the Angolans.

Sharing information has resulted in downplaying by government officials of the role of Cuban ancestry in traditional medical knowledge. For example, in my interviews with Cuban officials, I asked where the knowledge of various traditional and alternative treatments originated. Most officials credit recent advances made in Cuban medical research to information shared with medical professionals in other countries, especially China and Korea but also Mexico, Argentina, and other countries. One top official of a major research institute outside of Havana gave me what was a typical account of the origins of traditional and natural medicine in Cuba:

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[65] Many older doctors I interviewed told me that they first learned about the uses of traditional medicine while doing service in the military.

> Our cultural influences come from Spain, Africa, and China. Those are the three groups of the Cuban nationality. Who comes from Spain? Brilliant, cultivated, wealthy Spaniards? No, no. Ignorant criminals who came out from the jails to come here, ignorant people with no culture, people running away from justice, etcetera. You will have very little information about traditional remedies from those people. Who came from Africa? Young, strong men. Umm hmmm… Shamans were old men and not good for slaves.

And another said:

> Well, traditional medicine descends from the East, from the traditional medicine of China. The Chinese people are one of the first people to begin to use traditional medicine, including here. The formation of the first specialists in traditional medicine were with the help of the Asians. Yes, they have used it for many years...

The above statements imply that Cuba's revolutionary government, through its co-operation and sharing of information with other countries, is responsible for bringing traditional and alternative medical practices to Cuba. This position delegitimizes the preexisting knowledge of many traditional medical practitioners of Cuba's rich herbal traditions.

Undoubtedly, this denigration is in part due to the legacy of an officially atheist state, and the role that *Santeria*[66] and other religions play in most of Cuba's traditional medical practices. Therefore, *la medicina tradicional y natural* in Cuba is 'officially' a 'Cuban', meaning post-revolutionary Cuban, product and not a product of Cuban ancestry.

In the Special Period Cuba has therefore shifted from a larger, broader *internationalista* position in which Cuban knowledge and aid is unilaterally delivered throughout the developing world in the hopes of spreading their socialist mandate, to one where health information and technology is *shared* in the spirit of co-operation and solidarity.

The Belief in a Basic Underlying Structure of all Health Care Systems

In accordance with traditional socialist views of how a state should be run, the Castro government has placed emphasis on the provision of free and easily accessible social services for all, including those who were traditionally discriminated against, whether it be due to gender, ethnicity, economics, or rural locale. Prior to the Special Period, the use of traditional and alternative medicine was viewed largely as a way to legitimize inferior forms of medical care to the poor and those living outside the boundaries of large cities, one part of a larger international pattern of exploitation of the world's poor (Image II). This view was consistent with the predominant social theory of the time, Latin American social medicine, a school that saw social class as the primary indicator of health status. Therefore health conditions were understood as determined by the socio-economic context and political process (Laurell, 1989).

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[66] A popular religion in Cuba which is a syncretization of Catholicism and Yoruban religion, discussed at length in Chapter six.

Prior to the Special Period, Cuba emphasized a health care system that was community based, despite taking a very high-tech and biomedical approach to the provision of health care. Following the Special Period, out of necessity, the position on traditional medicine has taken quite a significant swing. No longer are traditional and natural forms of health care a method of legitimizing the provision of an inferior type of health care, but a way to salvage and defend Cuba's internationally-respected and famed health care system. As one MINSAP worker stated:

> The Special Period has been a great teacher for Cubans; we found ourselves in a very difficult situation and to figure out ways to deal with it, to keep going; and using Traditional Medicine was one way to do this.

The use of traditional and alternative techniques in Cuba has been officially accepted, but in a way that has allowed MINSAP to maintain its fundamental 'scientific' principles in the area of health care. This interpretation is because traditional medicine is accepted from a 'scientific' standpoint by government officials: 'scientific' studies are done on medicinal herbs to determine their efficacy,[67] acupuncture is used to replace expensive and hard-to-access anesthetics, homeopathic drugs are officially promoted to treat various illnesses (as opposed to 'persons'), and formally educated doctors are the only ones officially recognized as being competent to deliver any form of medical practice. As one MINSAP official stated:

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[67] Personal communication with Leoncio Padron, February 22, 1999.

> Traditional medicine deserves the same respect as allopathic medicine, and so only doctors are permitted to practice. This is because doctors already know physiology and anatomy - how the body works. It is only logical, no?

Legitimizing traditional and alternative medical practices through their bureaucratization has served to maintain the structure of the original biomedical health care system, using certain aspects of alternative and traditional forms of health care to plug the holes left from the current economic crisis. Aspects of different health care systems can be superimposed onto certain areas of another system because Cuba now takes the ideological position of Keane's Image IV (1998:231), which states that "nation states are seen as sharing certain important characteristics in the *structure* of their health services" (italics added). The replacement of certain aspects of one medical tradition with certain aspects of another medical tradition is consistent with such an ideology, since, if one accepts the view that all health care systems share a similar underlying structure, then it logically follows that individual parts can be interchanged with little difficulty or disruption to the original system. Further evidence of this ideological stance is found in the following statement regarding the Cuban use of homeopathic medicine, made at a public talk by Marta Perez:

> In Cuba we have invited doctors of homeopathy from many countries and many schools to come to Cuba and tell us about the type of homeopathy they use; how they diagnose patients, what types of medications they find most effective for certain illnesses. We take those aspects which we think are good, and we are now developing a Cuban school of homeopathy based on what we think works from the practices of all the other homeopaths.[68]

The fact that they can use "those aspects which we think are good" and by implication discard others, further implies a belief that homeopathy as a system can be dissected into useful and non-useful parts; and that those useful parts can be plugged into another health care system. This attitude can be seen in the following answer from another MINSAP worker.

> *In Canada traditional and allopathic or conventional medicine operate separately; I am interested in how it is possible to use them both together here.*
>
> This is one of the challenges that we have, that a doctor can be capable of using, without getting too excited about one system, all systems. We don't want doctors to say that they will only use allopathic [medicine]; we want to go to a doctor that is not only allopathic or is not only a traditional doctor, a *naturalista* we could say, but a doctor that is capable of using each system, and is capable of seeing a patient from the point of view that if you have a fracture, well, then, indisputably one must cast it; and if there is a surgical situation one must operate. One doesn't want to say that always they are going to cure with only one! But natural medicines are better for helping with recovery,

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[68] Talk given to the NOETIC Science Institute, November 1998.

> helping to heal the wound. I believe that we have to go to a doctor who is holistic, inclusive. There are patients that need complementary treatments; and so the doctor must apply acupuncture, and give them homeopathy. There are patients that must get moxibustion, and others that must get massage. It is not within the specialty of traditional medicine to believe in divisions for specializations - that the acupuncturist only believes in acupuncture, that the homeopathic [doctor] only believes in homeopathy, and that the physiotherapist only believes in their massages. I believe that it should be complete, holistic. I believe that there is a need to integrate it, and that the sick [person] is unique; and when one is confronted with a patient, it is better to bring both treatments.

Again we see the use of different aspects of medical systems being used within one system - a form of integration, the ultimate goal of Cuba's experiment with alternative medical practices.

Cuba has also looked into its own historical use of homeopathy in order to add national pride to the incorporation. A recent article in a popular Cuban magazine featured an article on the use of homeopathy in Cuba during the nineteenth century, complete with a photocopy of the cover of a book dated 1881 entitled *Manual Popular de Medicina Homeopatica* (Fleitas Salazar, 1998). One medical professor told me that while Cuba is currently looking to Mexico for help in establishing its school of homeopathy, it was Cuba that had originally taught Mexico about homeopathy. Cuba did officially practice homeopathy until 1959, when it was abandoned in favor of western biomedicine; however, it is resurfacing in the official system is moderated by the larger biomedical model of health care delivery.

Given that the Cuban Ministry of Health is collecting and sharing health-related information, and attempting to integrate what it calls *la medicina tradicional y natural* into the preexisting biomedical system, it would seem reasonable to conclude that the use of traditional and alternative medicine is viewed by Cuban government officials as being universally applicable, and easily transferred from context to context. Such a perspective further promotes the notion that the problem of global inequalities between nation states can be addressed by sharing generally compatible, *universally applicable* health technology. In this image (IV - Gesellschaft I), Cuba may continue to promote its *internationalista* ideology, albeit on a more dynamic, specific, and small-scale form, while also promoting its own national advances in medicine. Furthermore, by removing *curanderos* and other traditional healers from the equation, the Cuban officials do not have to address how the current health care reforms contradict their previous position that such forms of health care are a justification for providing inferior care to the world's poor.

But the question remains: How can Cuba manage such a drastic change in medical ideology while remaining consistent with its larger political ideology? The answer to this question can be seen through Cuba's shift from a Gessellschaft II (Image II) vision of world health to a Gessellschaft I vision (Image IV). This transformation in ideology is not so drastic, as several factors remain intact: an emphasis on society; the idea that all nations are linked through (and not isolated from) the happenings of the world system; and the recognition of worldwide patterns of exploitation (Image II) and inequalities (Image IV). Cuba claims to be simply following global trends to incorporate traditional and alternative medical practices, as recommended by international agencies such as the WHO.

Maintaining Cuba's Position Internationally

Globalization has resulted in an increased reliance on international organizations to provide validity of various social systems, laws, and even cultural practices, whether through a rejection and/or reaction (Appadurai, 1997), or through using them as a measuring stick to gauge success, as is the case in Cuba. The remarkable accomplishments of Cuba's post-revolutionary health care system have always been a source of both respect and bewilderment in the international arena. While it is clear that the Cuban government's main priority in the development of the post-revolutionary health care system was to provide good and accessible health care to the entire population, the success and recognition of Cuba's health care system has served a secondary role that has proved to be almost as important - the generation of symbolic capital (Feinsilver, 1989; Bourdieu, 1987). The generation of symbolic capital has simultaneously produced both legitimation and tolerance (if not support) of Cuba's political and economic system within the international arena.

Cuban authorities have used the move to a pluralistic health care system to show that they are keeping up with current health trends. In Cuba's top medical magazine, *Avances Medicos de Cuba,* articles about traditional and alternative medicine are commonplace. In the 1999 spring edition, the cover says *Naturaleza y Salud;* and features a story called *Medicina Natural: Una Revolución Verde*[69] (notice the reference to a 'revolution'). The first sentence of the article emphasizes the role of traditional medicine internationally, as well as Cuba's use of this system to provide sustainable health care:

> Natural medicine is the fashion in the world, but in Cuba it implies above everything the reinforcement of its pharmaceutical industry with national raw materials (Potts, 1999:44).[70]

Taking this approach, Cuba can portray itself as following global trends in health provision, and not simply making desperate attempts to salvage an economically-devastated system.

Cuba is recognized for having met all the criteria outlined by the WHO for an effective primary health care (PHC) system (Swanson et al., 1995); and Cardelle (1994) has traced how MINSAP's *médico de la familia* program has evolved to meet Cuba's changing health profile to the point that PHC can now deal with Cuba's more prevalent chronic, non-communicable diseases. Furthermore, in Cuba the WHO's Mass

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[69] Natural Medicine: A Green Revolution

[70] La medicina natural está de moda en el mundo, pero en Cuba implica sobre todo el reforzamiento de su industria farmacéutica con materias primas nacionales.

Childhood Immunization (MCI) program is accepted and practiced with great success (Mas Largo et al., 1994). In January 1985, Castro announced that Cuba would no longer compare its health statistics with developing countries; and would begin comparing them with the US instead (Feinsilver, 1989). Life expectancy had already reached a level equal to that of the US, and infant mortality rates were lagging slightly behind. In comparing its statistics to the US, Cuba hopes to show the international community that it is capable of achieving a health care system that equals the United States, its arch-nemesis ever since the revolution took place over forty years ago.[71]

Keane's Image IV is the dominant image supported by the WHO. In many parts of the world, economic crisis and political disruptions have led to severe shortages of certain modern drugs which are often imported, thereby forcing more people to utilize traditional medicine, whether government policy or not (Hyna and Ramesh, 1994). The WHO advocates the use of traditional medicine's *materia medica* to supplement expensive biomedical drugs, and traditional practitioners to act as vehicles for the provision of health care information and services (read: to be used out of *necessity*). As a result of its 1977 "Health for All by the Year 2000" resolution, many developing countries have taken action to develop

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[71] The US also uses Cuba as a symbol, representing a mirror image of their political ideology. See Bernell (1994) for a full review of the social and ideological issues surrounding US foreign policy toward Cuba.

policies and programs for the integration of traditional systems of medicine into the national and public health care systems. The effects of integration (as identified by the WHO) bring reciprocal benefits to each system: improve the general health care knowledge for greater human welfare, especially in view of the inherent possibilities for wider and more efficient population coverage; enhance the quality and increase the numbers of practitioners; promote the dissemination of knowledge relating to public health care; and increase a society's chance of reaching "Health for All by the Year 2000" (Hyna and Ramesh, 1994).

The WHO's position,[72] like Cuba's official position, argues for the application of useful aspects of traditional medicine and practitioners within national health care systems, while maintaining a basic structure that uses biomedical science as the foundation for the implementation of any medical practice (WHO, 1983). Cuba has further shifted toward the same ideological stance as the WHO, by accepting the WHO's rhetoric about the implementation of traditional medical practices without having to accept the underlying structure of these systems. This approach lends further legitimacy to Cuba's adoption and implementation of traditional and alternative health care techniques. In fact, one doctor told me that traditional medicine used to be looked down upon by doctors; and that they never would have considered using it, had it not been for both the economic crisis, and the fact that the *world is moving more toward acceptance of such medical practices.*

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[72] WHO, 1978, Alma Ata Declaration.

One exception in Cuba's adoption of the WHO's suggestion that countries should utilize traditional and alternative practices is that Cuba does not use traditional practitioners to aid in the provision of health care services. I was repeatedly told that this is because in Cuba there are so many doctors that it makes no sense to use *curanderos* or other traditional practitioners. As one MINSAP worker told me:

> Here in Cuba there are a lot of doctors. We don't need *curanderos*. OK, in some countries there are no doctors, they don't have enough doctors, or one must pay to see a doctor; but here there are lots of doctors and everything is free.

Denying the existence and the importance of this competing system, which in fact is flourishing on the island (see Chapter six for discussion), is the policy in order further to imply that Cuba is more 'advanced', or more like a 'developed' country.

Cuba's health care system, like any other, is measured primarily by how its health care indicators measure against those of other countries. The most often quoted indicators, and indeed those that appear to lend the most legitimacy internationally, are life expectancy and infant mortality rates (IMR).[73] Given Cuba's current economic crisis, which has resulted in drastic drops in caloric intake (a known primary cause of high IMRs), one would expect that health care indicators would have decreased significantly. However, even during the worst part of Cuba's crisis, health care indicators remained relatively stable; and after 1994 even made slight improvements. This situation is because during the special period, Cuba has directed even more of its resources toward maternal-infant care. This policy has been carried out in a number of ways, including the outfitting of all Cuban maternal-infant hospitals with peri-natal intensive care units; strict medical follow-ups for pregnant women, new mothers, and their infants; and the provision of extra rations for pregnant women and children up to seven years of age (Susser, 1993). While the primary reason for these increased measures is undoubtedly to benefit Cuban mothers and children, such measures serve to maintain much of the symbolic capital that Cuba has managed to develop over the last forty years.

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[73] Recently the WHO has begun to place more emphasis on the social determinants of health. For example, in the 1999 World Health Report, tobacco use, immunization coverage, and income levels are emphasized as being important indicators in determining health levels of a country.

Some anti-Castro commentators see the controversial, standard prenatal screening for pregnant women, and the provision of free and easily accessible abortions to women who wish to abort a fetus found to have a genetic abnormality, as responsible for Cuba's IMR. Furthermore, young women who find themselves pregnant have equally easy access to a safe and legal abortion without the associated stigma[74] of most other countries. The provision of safe and legal abortion also serves to maintain a higher life expectancy rate. According to Paxman et al. (1993), abortion is the fourth most commonly used method of birth control in Latin America; and yet only Barbados, Belize, and Cuba provide legal access to safe abortion. As a result, complications resulting from unsafe, illegally-induced abortion are considered the principal cause of death in Latin American women aged 15 to 39 years (Paxman et al., 1993; PAHO, 1985), not to mention the fact that one of every three to five unsafe abortions leads to hospitalization, which further results in the use of scarce and costly resources (Paxman et al., 1993).[75]

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[74] Mendoz (1999), in her interviews with 248 young women in Cuba, indicates that the main reasons given for having an abortion are interfering with studies, and not wanting to be a single mother. Mendoz claims that more than half of the women she interviewed went outside of the community to obtain the procedure.

Conclusion

The fall of the Soviet Union and other socialist bloc countries resulted in a drastic change in virtually every aspect of Cuban society, including its medical resources. Through a shift from Keane's Image II to Image IV, Cuba found a way to maintain its highly respected health indicators, which help to lend the Cuban regime international legitimacy. This position is especially important in the Special Period that has left Cuba with few allies and little economic support.

In my own experience in Cuba, I found that many Cuban women often spoke freely with me about their experiences with abortion. When I spoke to one friend about the "pro-life/pro-choice" debate in Canada and the US, she laughed and said that she could not believe how a country like Canada can be so advanced and progressive in some ways and so backwards in others. In Cuba there are three different types of abortion available depending on the stage of pregnancy, and abortion can often be scheduled for the same day as a request is made.

[75] Reports on the incidence of illegal abortion are difficult to verify (Singh and Wulf, 1991).

In adopting a 'pluralistic' system, Cuba has ensured that its approach is compatible with the WHO's view that the integration of medical systems is an effective way to modernize traditional medicine, giving it a place within a larger framework built and created by biomedicine. Such integration cannot occur unless one presumes that the medical systems involved have a similar structure. The Cuban Ministry of Health has taken traditional and alternative health care *practices*, not *systems;* and legitimized them through bureaucratization, and incorporation into the official health care system. *Curanderos, Santeros,* and other traditional practitioners of alternative health care systems in Cuba; while not illegal, are not given official recognition in Cuba; and their existence is downplayed by government officials in order to give further 'scientific' credence to non-biomedical practices. Information on alternative approaches to health care provision have been gathered from the international community (sharing of information); and then localized into a form that is consistent with Cuba's image of what form a health care system should take, how health care should be practiced, and how the world should be structured.

Chapter 5: Negotiating Meaning in the Clinical Encounter

In Chapters three and four I discussed the global factors (both innovative and constraining) placed on Cuba's national health care system, and how these factors have influenced and shaped the particular form that Cuba's official position on medical pluralism has taken. This chapter examines the attitudes of Cuban individuals concerning their national health care system. The reactions to and attitudes of Cuban doctors and patients toward the official use of traditional and alternative medical practices are then examined in order to illustrate how these 'innovations' are experienced at the practical level. This chapter also describes the unique character of the doctor-patient relationship in Cuba; and how this relationship affects, directs, and facilitates the incorporation of alternative and traditional medical practices.

The Clinic

One of the 440 policlinics spread throughout the island of Cuba is located in the suburb I am calling Alonjas in the capital city of Havana. This policlinic, like all others in Cuba, provides health care, free of charge, to all residents living in the surrounding area. Policlinics in Cuba are open 24 hours a day, seven days a week; and deal mostly with primary level health issues by providing specialized care, mainly for patients with chronic illness, but also provide some forms of emergency care. Patients are referred to the various specialists at the policlinic by their family doctor, who serves as the first line of defence in the primary health care sector. This clinic employs several nurses, technicians, pharmacists, administrative staff, and specialists in obstetrics-gynecology, physiotherapy, dentistry, dermatology, psychiatry, paediatrics, internal medicine, and more recently acupuncture, homeopathy, and what is called a specialization in traditional and natural medicine. I spent ten months in this clinic, mainly in Anna's *consultorio*[76], a specialist in physiotherapy and homeopathy.

It is 8:45 a.m. and I have just arrived at *Policlinico 26 de Julio*. There is the usual crowd of patients gathered around the front information desk, waiting to make appointments to see one of the various specialists who hold their *consultorios* here every weekday morning and some afternoons, or to get the official clinic stamp on their medical prescriptions. As I make my way down the hall, other patients lounge about waiting for their turn in the *cola*[77]. Several doctors, nurses, and technicians walk through the halls looking for patients, chatting with each other, and trying to solve everyday problems that inevitably arise within the clinic walls. I arrive in front of Anna's door but she has not yet arrived. The sign on her door says office hours are from 8:30 a.m. to 12:30 p.m., but Anna has no car and the bus service near her home is very unreliable. So most days she must hitchhike to work; and if she cannot get a *botella,*[78] she must walk for about 30 minutes. In the hall outside Anna's door, patients greet me with friendly smiles and ask me how my studies are going, how is my family, and whether or not it is cold in Canada right now. Others stop me to complain about their various aches and pains, report to me on the relative success of different medications and treatments they have been receiving, and ask me if I know when Anna will arrive.

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[76] The name used to refer to both a doctor's official office hours and the office itself.

Once Anna arrives, just before 9:00, she calls in her first patient from a list she picked up at the front information desk. Today is a physiotherapy day, and so patients are called in order from a list; on homeopathy day the patients form a *cola;* and Anna simply calls *proxima* (next), and patients enter in the same order as they arrived.

The office is dark because the day is overcast and we do not have the usual light from the sun coming in through the window. Once there was a light in the office but it broke several months ago; and Anna has been waiting to have it replaced. She complains that she cannot see to write her patient's prescriptions, and so we get up and move her desk closer to the window. After a few minutes of friendly chatter between Anna, a physiotherapy student, and myself, the first patient comes through the door. She says she has a lot of pain in her knee. After examining it, Anna tells her that she has *artrosis;* and needs fifteen sessions of laser-

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[77] Meaning line-up, but in Cuba it takes a specific form in that people remember their spot in the *cola* by remembering the person in front of them and not by actually lining-up.

acupuncture, must exercise more often, and lose some weight. The patient insists that she has been trying to lose weight but cannot. Anna tells her she will lose weight if she stops eating sugar and fried foods, increases her intake of fruits and vegetables, and exercises. The patient laughs and promises to try, and leaves with her green card detailing her laser-acupuncture treatments that she must give to one of the six physiotherapy technicians working today. A second patient enters the *consultorio;* but before she can be examined, there is a knock at the door and Enrique, one of the clinic's several technicians, enters with a disappointed look on his face and a broken laser-acupuncture cord in his hands. Anna lets out a loud sigh, slouches down in her chair, puts her hands on her forehead, and says "*Oh Tracey, eso es Cuba*!" (this is Cuba); a phrase I heard often, as Cubans would say this whenever a problem arose considered to be typical of the times.

Anna reminds me that things never used to be this way; "*Antes*[79] things were better, we had the medicines we needed, we always had water and electricity, and if something broke we fixed it or replaced it." But today if something breaks everyone makes an attempt to fix it, in sometimes magnificently creative ways; but if such attempts fail, they wait until the scarce materials needed to fix it appear. Today in the clinic there

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[78] The name given for a free ride from another Cuban with a car. The word means bottle, and is named for the shape one makes with their hand while hitchhiking.

[79] Cubans often use the words *antes* (before) and *después* (after) to refer to the time before and after the Special Period. This is an interesting observation, as in Rosendahl's (1997) ethnography conducted immediately before the Special Period, she notes that these terms were used to refer to the time before and after the Revolution.

is occasionally no electricity, there is often no running water, and there are always shortages.

Narrative of a Cuban Patient[80]

The day begins; light from the sun penetrates the room. The day is cloudy because of the presence of the *frente frio* from the north that brings rain, wind, and cold. I think that I will need my coat because I feel *friolente*[81] in my body that is bothered by the cold that I am suffering from. For many days I have been talking to my friends in the *colas de las tiendas*[82] and on *la aspirina,*[83] and I have noted that they are coughing and have runny noses. It seems that they have all caught the *Lucrecia*[84] that has been going around. Yesterday I made an inhalation of menthol leaves like my grandmother taught me to do, but it did not make me feel any better. In fact, I woke up today feeling even worse; and so today I will stay at home. No, today instead of going to work I will stay in bed. My mother comes in and covers me with blankets because she believes that the best thing for a cold is to cover yourself with a lot of blankets, and to take an aspirin with hot lime juice to stop the cough. I put on some nice music and close the shutter so that I will not catch any of the cold outside air that will hurt my lungs when I am like this.

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[80] The narrative below illustrates what Dr. Valdes tells me is a typical illness account of a Cuban patient. Dr. Valdes wrote this narrative for me as an aid to help me understand what he calls the "idiosyncratic nature of the Cuban patient."

[81] A feeling of extreme cold. Cubans often say things like "yo soy friolenta," loosely translated as, I am someone who is easily or always cold.

[82] Lineups at the store

[83] The aspirin - a bus

[84] A cold

Later, I will go to see my family doctor who has a free *consulta* here on my block. I am a *mestizo*[85] but even so I don't believe much in the effectiveness of the old treatments for the flu or for colds. Twelve hours of the day have passed and the sun begins to rest; however, the pain in my bones and my joints persists. My mother is worried, and the elderly people in my family and on my street have already given their commentaries on all the treatments that I can take. If I take orange leaves, they will feel better; and so I do. *Todo el mundo se sienta al médico.*[86]

The night is cold, and I look for a heavy blanket to cover myself. The temperature in my room begins to feel warm. My cough becomes dry, and the children in the house tell the older people that I have a *toss de perro*.[87] All the members of my family come into my room, and try to wake me to go to the *médico de guardia*.[88] They are very emotional, and tell me that I need an x-ray of my lungs because I look bad to them; and so just in case, I go.

"Doctor, do you remember me? When we were in high school together? I was the best dancer at *las fiestas de Rosita*.[89] But today *estoy hecho tierra*[90] because *Lucrecia* has caught me like everyone else at my work. Do you think you could send me for an x-ray?"

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[85] A person of mixed ethnicity. There is a stereotype that all Mestizos and Afro-Cubans believe more strongly in traditional and folkloric medical practices than do the Cubans of Spanish descent; but in actual practice, many Spanish Cubans practice various religious healing ceremonies.

[86] Everyone feels as though they are a doctor.

[87] Dog cough - a common name for a dry, raspy cough.

[88] The doctor that works at night.

[89] A phrase used to denote small (or not so small) house parties

[90] Literally, I am making dirt - I don't feel well.

"Ah, *asere*[91], let me look at you first."

He examined me and then gave me five prescriptions: aspirin, penicillin, *venadrilina*[92], eucalyptus, and a saline solution; but I am not going to buy any of them in the pharmacy because he did not make me an x-ray.

The above narrative contains many 'Cubanisms', which are terms or phrases said to reflect concepts and ideas that are unique to Cuba, its people, and its socio-political and economic context. Some of these Cubanisms are as follows:

Lucrecia

Shortly after I arrived in Cuba, a Colombian *novela*[93] called *Café Con Aroma de Mujer*[94] premiered on one of Cuba's two television channels. The *novela* played from nine until ten in the evening every Monday, Wednesday, and Friday evening. During those three hours the streets were empty; and the only sound that could be heard in the otherwise noisy streets was the sound of the *novela* blasting from every Cuban home. Even the men, the majority of whom aggressively maintained that they did not watch *novelas,* could always be found sitting in front of the TV, intently focused on the unfolding drama.

It is from this *novela* that the term *Lucrecia* originates. Lucrecia, one of the novela's main characters, was a wealthy woman from a distinguished family who quickly revealed herself to be a deceitful and unfaithful wife who stood in the way of her husband and his true love, Gaviotta, a beautiful peasant with a fabulous voice. Shortly thereafter, I noticed that many of the patients who came into the clinic with colds or the flu would claim to have been "caught by Lucrecia." Due to the popularity of the program, I knew of no one who did not understand this reference. When asked to explain this reference to me, most people laughed and said they just called a cold Lucrecia because she was such a bad woman. However, a few people explained to me that they believed Lucrecia to be a cold or illness caused by *brujería* (witchcraft). When asked to elaborate on why they thought the origin could be from *brujeria,* they quickly reminded me of how Lucrecia initially tried to manipulate her husband to fall in love with her (or at least to become sexually attracted to her) by preparing certain foods with particular herbs that would cause him to forget his true love in favour of his wife.

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[91] A very familiar form of address.

[92] A spray normally used for asthma patients.

[93] A novela is like a soap opera; only in Cuba, they usually run for no longer than a year.

[94] Coffee with the scent of a woman.

In Cuba, one of the most popular uses of *brujería* is for 'love magic.' Such love magic was variously described to me as taking the form of a religious ceremony in which a jilted or neglected lover or admirer performs a ritual to 'tie' the desired person to him or her. Alternatively, a person perceived as 'coming between' the individual and his or her loved one can be made the subject of a curse. This is generally recognized as an abuse of power and a 'wrong' thing to do; however it is widely practiced just the same.

Todo el mundo se sienta al medico

The phrase "everyone feels as though they are a doctor" is easily observed in the homes of the families I knew in Alonjas. I recall several examples in which an individual would become sick; and everyone had some sort of medical advice to offer, ranging from the drinking of a type of tea, avoidance of certain foods, or the ingestion of some type of medication in a popular, traditional, or biomedical form. One time when I myself was feeling ill with a stomach ache, I was given spoonfuls of a honey and garlic mixture, chamomile tea, a homeopathic remedy called Rhus Tox; and was told to eat a lot. One neighbor even offered intravenous fluids. Furthermore, my entire street was quickly made aware of my state of ill health; and I was repeatedly asked about my symptoms, and what I was taking and how I was feeling.

He examined me and then gave me five prescriptions: aspirin, penicillin, venadrilina, eucalyptus, and a saline solution; but I am not going to buy any of them in the pharmacy because he did not make me an X-ray.

This statement contains two common occurrences that I observed at the clinics where I conducted my participant observation. First, I noticed that patients often requested X-rays or other unnecessary procedures (by biomedical standards) to give them some sort of physical proof of their illness. When the doctor refused, the patient often would become upset; or beg the doctor to perform the procedure. Sometimes the doctor would eventually cave in, and request that an X-ray or some other procedure be performed. At other times he or she would try to explain to the patient why this was not necessary. I was told by Dr. Valdes, as well as by some patients, that if a requested procedure were not performed, the patient would sometimes disregard some or all of the medical advice given because they did not believe that the doctor had properly diagnosed them.

The second observation was that patients would often be prescribed a variety of medications from a variety of medical traditions. Homeopathic drugs and herbal drugs were sometimes prescribed together, or biomedical medications would be prescribed with massage and acupuncture. In most cases both the patient and the doctor did not see a conflict between uses of different medical traditions.

Asere

The word *asere* is a very familiar term of address; in fact it is so familiar that some consider it a vulgarity. I was told that the word is not Spanish, but derives from the Yoruba language. The importance of the doctor calling the patient *asere* is that it reflects the familiarity of the doctor-patient relationship in the clinical encounter. There is an abundance of literature that portrays the doctor-patient relationship within biomedical practice as a structured and hierarchical interaction in which the doctor is the sole owner of medical knowledge, who delivers his or her expertise to the patient, who is a passive receiver (see Wartofsky, 1982, Good and DelVecchio-Good, 1993, and Davis-Floyd, 1992 for some examples).

According to Baer et al. (1997), the maintenance of the hierarchical relationship between doctor and patient in biomedicine is a direct result of the biomedical hegemony that downplays the social, political, and economic influences on disease and disease patterns. In Cuba, the structured and hierarchical relationship between doctor and patient is not encouraged or maintained, because the social role attributed to doctors is not elevated to the same levels as it is in capitalist societies (see discussion of doctor-patient relationship in this chapter). My interviews revealed that doctors are perceived as neighbors and friends, who, while respected, are not perceived as being outside of the social reality in which the majority of Cubans live. I will illustrate this point with the following example that occurred during my stay in Alonjas.

One evening I was invited to the home of one of the elderly patients in my study for dinner. Upon arriving at her home, I was greeted by Julio, her doctor, whom I also had come to know quite well. I had assumed that he was there to check up on Lilliana; but soon realized that he, like myself, was in Lilliana's home as a dinner guest. The two interacted like old friends (even though he was easily fifty years her junior). After he left, I questioned Lilliana about her relationship with Julio. She informed me that the two of them got along well; and since he lived only two blocks away, they had become good friends. I later told Anna about my conversation with Lilliana; and she verified the scenario, explaining to me that many of her own friends were at one time, or still are, patients of hers. In the home where I lived, patients often stopped by for a quick check-up or to ask questions about their health care; but they also stopped for social visits, and invited the family I lived with to their homes for coffee, lunches, and dinners.

I am a Mestizo but even so I don't believe much in the effectiveness of the old treatments for the flu or for colds

Cubans are a *mescla.* I was reminded of this on numerous occasions. The mixture of African, Spanish, Chinese, and other origins has created the Cuban ethnicity. In fact, the ideal Cuban is often represented as a person of mixed ethnic origins (see Rosenthal, 1997). This was a recurring theme in the unofficial health care sector discussed at length in Chapter five.

Las colas y la aspirina

Cubans spend a great deal of time waiting in *colas* (lineups), at the *bodeca* (store) if an item is being sold at a good price, and for *la aspirina* (the bus). The bus is sometimes referred to as an aspirin because of the relief that it brings when it finally arrives. This term, I am told, began in the special period, when gasoline shortages made transportation a problem.

The Doctor-Patient Relationship In Cuba

The relationship between the doctor and patient within western biomedicine is structured so that the acquisition of knowledge sets the terms for its control. This situation leaves only a passive role for the patient. The structure of this power relationship is maintained through patterns of discourse between the doctor and patient in four ways:

1. The use of language (Wartofsky, 1982) - Often the terminology used in western biomedicine is so cluttered with complicated jargon that only those with extensive medical training are able to understand what is being conveyed to them about their illness by the doctor. This jargon serves to mystify the condition; and leaves patients feeling as though they cannot understand what is wrong with them, nor can they participate in solutions.

2. The medicalization of nonmedical problems (Waitzkin and Britt 1989) - A good example of this can be seen in childbirth practices in North America. In Canada and especially in the United States, childbirth is treated as a medical emergency (Davis-Floyd, 1992). Upon entering a hospital, a labouring woman is immediately placed in a wheelchair and taken to a room where she is strapped to machines which are used to tell the doctor how well the birthing is progressing. The role of the woman in the actual birthing process is thus minimized, and instead it is the doctor who assumes control over the situation.

3. The tendency for western biomedicine to marginalize those social issues that generate personal troubles in everyday life - for example, alcoholism is considered a social issue and is not treated as a health issue; only manifestations of alcoholism in the form of visible illness are treated by biomedical doctors. This separation of social and individual illness

reinforces ideas of individualism, and negates the role of society in its members' states of health.

4. The use of biomedicine to create a culture of prestige among doctors - The social status of biomedical doctors is elevated within capitalist societies through many mediums, such as inflated wages, as doctors are allowed to exploit and derive direct and disproportionate profit from medical knowledge within the pharmaceutical industry (Wartofsky, 1982). As a result, doctors are often viewed as culturally, socially, and economically unapproachable.

Theoretically speaking, differences in the active participation of both the patient and society as a whole can be directly correlated with system of government. Within most capitalist societies, medical knowledge is seen as privately-owned meaning. It is treated as belonging solely to a group of privileged individuals; namely, doctors. This perception is directly related to notions of property rights prevalent in capitalist countries, where medical knowledge is seen as the property of the possessor and not of the provider. While medical knowledge is gained in medical schools that are publicly funded, it is the acquisition of this knowledge that gives its ownership to the doctor (Wartofsky, 1982). Therefore, while medical knowledge is publicly produced, it is privately owned. The failure to recognize medicine as socially-owned knowledge, and thus an inherent right of the individual, leads to many problems within health care policy. Of primary importance is the disempowerment of patients over their own state of health, which leads to a state of passivity and helplessness that does little to alleviate the experience of illness. In a study conducted by Morse et. al (1991), it was determined that the problem involved in incorporating traditional medicine into a biomedical system is that the patient is not allowed to define his or her own state of health; this situation led to a passive rather than a participatory role in healing. Furthermore, the specialization of the caring (nurse), curing (doctor), and counselling (social worker) roles in a biomedical system serves to limit the notion of holism by drawing a distinction between care and cure that is not drawn in most traditional medical systems.

In socialist or communist countries, the role of the patient and society as a whole is active, ideologically speaking. In reality, it has been shown that a socialist revolution does not guarantee the alteration of a hierarchical doctor-patient role. This may be seen in the example of the medical system employed in Stalin's Soviet Union, where the medical encounter has been described as tension-ridden and full of distrust and animosity (Waitzkin and Britt, 1989).

Health care delivery within a communist or socialist country is beset with many problems in attempting to implement pluralistic health care policy. Since medicine is provided by the state, often choice becomes limited; as a result, traditional medical practices have almost disappeared (Pederson and Baruffati, 1989). However, it must be restated that in order for a health care system to be effective, it requires the participation of people in their health care system, in whatever form that may take. Medicine is a social product. In practice, the western biomedical system leaves the right to health in the hands of the doctor and not within the hands of the patient. The rights of the patient are therefore abstract, as it is not the individual's right to have free health care; it is the doctor's responsibility to provide it. Therefore, in western biomedical systems, medical knowledge is seen as the personal property of the doctor; whereas in most socialist countries, it is recognized as socially-owned, and can therefore be recognized in practical terms as a right. This is an important distinction at the international level as well, because as long as international policy makers continue to promote western political ideals and the primacy of the individual right to property ownership over the rights of the community or the greater society (and thus viewing health care as a privilege to be earned by individuals), they cannot possibly recognize health as an inherent right.

In a comparison of Cuba's and Britain's health care systems, Susser (1993) argues that the success of Cuba's health care system is the result of two things: 1. continuous evaluation with flexible response; and 2. community involvement. This feature he compares to Britain, where there is also equal access to health care but not equal states of health, which are measured by mortality rates among different social classes. This situation is also true in Canada among Native people, who have the right to free and accessible health care accorded to them in treaty law, but who experience huge disparities in states of health when compared to the general Canadian population (Frideres, 1988).

In my research I found support for the socialized role of medicine in Cuba that is not only evidenced through the 'medicine in the community' project but in the doctor-patient relationship. For example, in one interview[95] with Anna, I asked her about her relationship with her patients:

> My relationship with most of my patients is very good. Occasionally there is one who is a problem; but that is normal, no? Many of them become friends of mine. You know Blanca and she is my patient, and I got to know her from being my patient. So they come to my house or they call me on the phone...
>
> *And it doesn't bother you when they call you on the phone?*
>
> No, no, it doesn't bother me; if they have a problem, well, I understand that it is logical that they would want to talk to me if there is something wrong. I give them my address and my telephone number, which is not mine but my neighbors - so maybe they bother my neighbour (laughs). But I do this so they don't feel alone or with no place to go just because I am not working or I am on vacation. If I leave the city, then I refer them to a colleague of mine to see while I am away; but in reality I think that is a good way of not leaving them floating in the air. If it is a patient of mine who has a problem, and I believe that they can wait a week and they are not going to have any more problems than the one they already have, well, then, I don't tell them anything because I don't want to see them on my vacation week (laughs). Oh, but I think it is good, we have a lot of trust. If I give them my phone number, I know they will call if they have problems; but if it is not a serious problem, they won't call.

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[95] Unless otherwise indicated, all interviews are translated from Spanish.

Likewise, in an interview with Isabel, she made the following comments about her relationship with her family doctor:

> The family doctor, we have one for each block of houses, maybe two blocks but probably one, so she knows everybody. They are young people, they are very nice; and so our relationship is fine. Yes, they are like our friends.
>
> *How so?*
>
> Well, I told you that I can go to her house. I don't like to do that in the evening; but I can, and I say "please take my blood pressure because I have a headache," and I know that she knows that I have high blood pressure, and so that is no problem. She takes my blood pressure, and she is at home; and so it is a very good relationship.

At the clinic in which I spent the majority of my days, the topic of the doctor-patient relationship would often come up; and Anna had some very interesting things to say about it. There was a patient who frequented the clinic, but did not appear to have any obvious health problems. I asked Anna why she thought this woman came to the clinic so often. She told me "some people, especially the older ones, come to the doctor because they want to speak to someone. I think this is good, because to have someone to talk to is also good for your health." I agreed with her, and she asked me if the elderly in Canada don't do this. I told her that some did, but that most considered this to be a strain on our health resources.

The topic of Canada's health care system, and how the doctors in Canada treat their patients, was always a recurring topic of conversation with many of the doctors in the clinic and in many of my interviews. Anna told me that she had heard that depression was a big problem in Canada, especially among the older population; and she had many theories as to why this was so.

> I believe, in Canada, depression is a big problem because the people feel alone. When their children turn eighteen-years-old, they go away to study in another place; and they leave their parents alone. I also think that Canadians feel cold sometimes for the climate, and this keeps them inside their homes alone. Do you know that the soul is hungry, and the only way to feed it is with attention and love.

Another doctor in the clinic said "*no puedes ayudar friamente*" (you cannot help coldly). This point speaks very much to the social aspect of the doctor-patient relationship in Cuba. My observations and interviews definitely indicate that both doctors and patients believe and are aware that there is a social dimension to illness, and that having a warm and compassionate relationship with one's doctor is a key factor in the successful treatment of many patients.

La Flaca

In order to illustrate the above point more clearly, I will use an example of one patient who frequented Anna's *consulta*. The patient, whom we all referred to as *la flaca* because she was unusually thin[96], was a single mother of twenty-five years, who, it was later determined, was a hypochondriac. She made her first appearance at the clinic in late December of 1998, complaining of insomnia, lack of energy, and a general

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[95] Cubans often refer to people by a physical characteristic. For example *la gorda* - the fat one, *la alta* - the tall one, *la rubia* - the blonde one. Many of these descriptions would be considered rude or inappropriate in Canada, but in Cuba people do not appear to take offense.

feeling of malaise. Anna asked her a lot of questions about her personal life and her diet. She told us that she is never hungry, and relayed her sad situation at home - how difficult it is to raise her son alone, how her husband deserted her for another woman, and how she has very few family members close by. Anna encouraged her to get out of the house more often, prescribed her a homeopathic remedy, and told her to return in a few weeks. Less than two weeks later she returned, complaining that she did not feel any differently. Anna encouraged her to keep taking the medication and to return next week.

The next week *la flaca* returned again with a gift of a necklace, a scarf, and a cloth rose; and stated that she had found a lump in her breast, and believes that she has breast cancer. Anna asked me to block the door to prevent other patients and technicians from entering while she examined the woman's breast. Anna could find no lump, but the woman insisted that there was one. Ana explained that although the patient was fine, she was going to prescribe her a Bach Flower remedy to help her with her anxiety; and asked her to come back again in a week. She returned exactly one week later; and explained that she still felt bad, and that she had contracted an infection of some sort. She explained to Anna and me that she does not know how she could have received such an infection because she keeps her fingernails very clean,[97] and she never eats

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[97] Cubans generally take very good care of their hands and fingernails, as they are seen as a sign of being clean and well groomed, both valued characteristics among Cubans.

mani.[98] Furthermore, her menstruation was abnormal, and this also had her worried. Anna joked that she was surprised that the patient menstruated at all, being so thin. Nonetheless, Ana sent her for a blood test; and told her that she would call her at home with the results in about two to three days.

A little more than one month later, *la flaca* returned, with big pieces of coconut cake for both Anna and me; and as she took a seat, she asked Anna how her daughter was feeling. Anna told her she does not have an infection, but still *la flaca* insisted that she was ill because she felt so bad. She believed that the medications are helping her a little, but that something more must be done. Anna changed her homeopathic prescription, and told her to try it for a few weeks; and if it didn't work, to come back.

Two weeks later she came back again - this time with pain in her knees, hands, and wrists. Anna offered her a pastry that one of the technicians had brought in for us, but she refused it; and said that the new medication was helping her to sleep better, but that she still had no appetite and very little energy. Anna asked her how she expects to have any energy if she doesn't eat; and then told her to give it more time, and invited her to come by her house if she does not feel better. *La flaca* took Anna up on her offer; and visited her at her home, where Anna gave her another type of homeopathic medication. As she left, *La flaca* invited Anna to her son's birthday party the following weekend. Once she was gone, Anna told me that she believes this woman is a hypochondriac; and that she is just very lonely, and needs to find herself a boyfriend or make more friends.

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[98] Peanuts that are sold on the street are believed to sometimes cause sickness

Three weeks later *la flaca* returned again. Her son was feeling better, but she was still sick. Anna told her she did not know what to do, because what she had been giving her should be working. Her tests indicate that she is fine, but she needs to eat more. Anna recommended that she see a psychologist and writes her a referral; but three days later she returned to Anna's *consulta*. She brought us pieces of a very sweet cake, and asked Anna why she didn't come to her son's birthday party. Anna told her that she had to wait at home all weekend because she had people installing a new door for her. While she was there, several patients came in to pick up prescriptions. *La flaca* told me that she saw me on the street the other day, but that I was too far away to hear her shouting at me. Anna asked her if she went to see the psychologist; and she says, "no, not yet." Anna appeared to be slightly annoyed with her, but she continued to listen to her talk about her health problems for almost twenty minutes. Anna insisted that she must see the psychologist. However, four days later she returned again; and Ana becomes very irritated. "How can I help her when she will not take my advice?" she asked me. I told her I do not

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because of the unsanitary manner in which they are handled before distribution.

know. *La flaca* insisted that she has an eye infection and needs some antibiotic drops, and she showed Ana some other medications that another doctor had given her.

One week later and *la flaca* was back, this time bearing a plant as a gift, and with her young son. Anna accepted the gift, and begged her to tell her what the real problem is. *La flaca* began to cry, and said that her life is hard and that she is very lonely. She talked about how it is very difficult to raise her son on her own; and that her ex-husband has money and a new house, and her son prefers to be there with him and his new wife and child. She was afraid that her son will move in with her ex-husband and leave her completely alone. Anna comforted her; and told her that she agreed that this is not fair, and that most men do not understand the pressures and problems associated with being a woman. Anna then explained that homeopathic medication and psychotherapy might begin to resolve her problem, and help her to feel better about herself. This way, Anna explained to *la flaca*, she would not have to create other illness to get attention. Anna then turned to *la flaca's* son; and told him that he must be good to his mother because a mother's love is the strongest love there is; and that no one will ever love him as much as his mother does, including (she said with a strong emphasis) his father. They talked for a little while longer, and when she left she promised that she would see the psychologist.

When I returned to Cuba over five months later, I asked Anna what happened to *la flaca;* and if she ever went to see the psychologist. Anna told me that she saw the psychologist a couple of times; but then she fell in love, and so now she is better. Anna had even met the man, and told me that he is a wonderful person – very kind, affectionate, and with a good job. I laughed and questioned her again "Really? She is all better because she fell in love?"

"But of course," replied Anna: "love is the best medicine for everyone."

I find that the events surrounding the treatment of *la flaca* to be very telling of the doctor-patient relationship in Anna's *consulta.* Anna took *la flaca's* explanation of her illness very seriously, but also questioned her about her personal situation. When the phosphorus did not resolve *la flaca's* situation, Anna questioned her more about her home life and her feelings about it. Immediately, Anna assumed that *la flaca's* personal life was affecting her state of health; and treated her accordingly with a homeopathic remedy (*Pulsatilla*) that is generally used for depression. When no resolution to the problem was made, she tested her to try and determine if there was in fact a biological origin to the depression. When a biological origin to the illness was not apparent, Anna insisted on psychotherapy but complemented with homeopathy. Anna was aware that the patient's personal situation was the cause of her insomnia, loss of appetite, and hypochondria. In the process of her treatment, Anna came to know her quite well; and the two became friends. Anna even spoke to *la flaca's* son, urging him to help his mother through her difficult emotional time. It was logical that now that *la flaca* had found love, she should feel better. In Cuba, one's social situation is directly related to one's state of health. Hypochondriacs are not marginalized; but their condition is taken just as seriously as any other form of illness, despite the fact that it does not have a biological origin.

Waitzkin and Britt (1989) emphasise the doctor-patient relationship within Cuba's health care system as a key factor in its success. They argue that because Cuba's doctors are paid modest wages and are not coded as authoritative or superior citizens (as they are in most other countries), the doctor-patient relationship is very trusting, resulting in a higher rate of patient co-operation and recuperation. Doctors are perceived to be just like everyone else. They must participate in community activities and carry out their mandatory social duties like everyone else. For a doctor, this usually entails two years of service in a community where they are most needed; or if the person is so inclined, he or she may be required to carry out medical duties overseas. While Cuban doctors are greatly respected and generally trusted, they are still ultimately seen as neighbours, friends, and family, with very little mystique surrounding their position.

Reciprocity

Another interesting occurrence within the doctor-patient interaction in the case of *la flaca* was the practice of reciprocity. I observed many cases of reciprocity during my observations at the clinic, especially among repeat patients.

Reciprocity in Cuba is a very complex and widespread phenomenon, and every Cuban participates in several reciprocal exchanges with virtually every person with whom they associate. In Cuba, it seems almost a necessity that one have an extensive network within which one can exchange information and obtain access to certain items (e.g., a telephone), favours, chores, and goods in general. Both the economic and social components act to build and strengthen social relations among individuals in Cuba (Mauss, 1969). According to Rosendahl (1997:41), reciprocity in Cuba differs from that of most other Latin American countries (see Hugh-Jones, 1992) in that it is "not organized on the community level but more informally, although it still has rules and a structure."

Another interesting difference in the reciprocal activity of Cubans is that one of the most important commodities that are exchanged is information. The reason for this is that in Cuba many items are scarce; and when a person learns of the location of a scarce item at a reasonable cost, this becomes valuable information that can be given to those with whom one has any sort of social relationship. The exchange of information appears to be an important and integral aspect of any social relationship in Cuba (Rosendahl, 1997: 41-50). One example from my own fieldwork occurred when I was in the agro-market picking up some vegetables. An elderly man motioned to me. After answering several of his questions about who I was, since I was obviously an *extranjera*, he asked me if I would be interested in buying some butter at a very good price. Since it had been some time since I had real butter, I took him up on the offer and bought a small block of butter from him. When I returned home, Sophia asked me where I got the butter; and I told her, from a man at the agro-market. She looked puzzled, and asked me how much I paid. I told her one American dollar. "That is a great price!" she exclaimed; and asked me to please tell her exactly where I saw him, and to describe his appearance. The next day a friend of hers was over at the house, and I overheard her relaying the information about the butter I had purchased. This was obviously a valuable piece of information for Sophia that she could exchange with her friend. In fact, I was often told that in Cuba it is very important to have a good relationship with your neighbors because without them one cannot survive.

According to Rosendahl, reciprocity in Palmera[99] is usually balanced in nature; exchanges are more or less equal in value, and are expected to be returned within a certain time frame. I, however, found many exchanges to be more generalized in nature, with the important thing being not so much the value of the exchange but that an exchange in fact took place (Sahlins, 1972). For example, on a return trip to Cuba, I brought a large package to the grandparents of a Cuban friend in Canada. The delivery of this package was perceived by the grandparents to be a huge favour, and they kept asking about how to repay me for my trouble. I assured them it was no trouble, and that I was happy to do it. Nonetheless, a few days later the elderly man took the bus into town to bring me a bag containing five mangos. It was mango season in Cuba; and if there was nothing else to eat, there were mangos. The hour and a half bus ride, and the sheer inconvenience for this man to bring me the mangos that I could easily access for very little money even to a Cuban, did not seem to make any sense to me. Sophia assured me that he had to do something because I had done him a favour by bringing the package from his grandson.

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[99] A pseudonym for the town in which she conducted her fieldwork.

Reciprocity also exists in the doctor's office. The practice of reciprocity in Anna's *consulta* is a perfect example of how relationships are built and maintained; and subsequently, even good friendships are forged. Almost one-third of the patients who came to the clinic to see Anna came with small gifts such as fruit, cakes, juice, coffee, jewelry, soap, and other toiletries. Repeat patients (such as *la flaca*) were more likely to give gifts than first-time patients. Sometimes patients brought Anna things they knew she needed. For example, one day, during a homeopathic *consulta,* there was no paper to record patient histories; so Anna wrote on the insides of files, and joked that she would soon have to write on her hand. The next day one of her patients came in and gave Anna a large stack of paper. Additionally, Anna sometimes used her patients (and other doctors, nurses, and technicians) as a pool from which she can get information. Many of the patients who came to the clinic were repeat patients, and so Anna came to know them reasonably well. To those patients whom she knew, she would sometimes mention that she was looking for something, such as a new door, or a new motor for her fridge. Often, at least one patient would return for a subsequent visit with information about where to get the desired item for a good price. Usually the gifts were small items. However, during one visit to Anna's home, I complimented her on her coffee table; and she told me that it was a gift from one of her patients. Likewise in the home where I lived, one evening we were all treated to a meal in a very popular and expensive restaurant, compliments of a patient of the surgeon.

The Setting: El Policlinico

Based on my ten months of fieldwork in a *policlinico* in Alonjas, I was able to witness the doctor-patient relationship in Cuba firsthand and on a day-to-day basis. The following is an excerpt from my field notes dated September 28, 1998:

> My initial observations and impressions of the clinic:
>
> Things look a little run down and crowded. There does not appear to be any order or organization in this place. It is darker than any medical clinic I have seen in Canada, and the equipment seems to be old and out-dated. In Anna's

> *consulta* people interrupt constantly: anything from a restless patient in the hall to someone offering coffee. The patients seem completely OK with my presence; and in fact, many try to include me in the conversation with Anna; some even try to speak English to me. Most look at me while they are telling Anna about their health problems - they do not seem shy or bothered at all. When Anna tells them what I am doing, they always smile and say something nice. Most patients kiss me and/or Anna in greeting or when they leave. A lot of the technicians and other doctors at the clinic kiss me too. I had expected that my presence would create some discomfort or at least pose some sort of a hassle, at least for Anna; but it does not appear to be so. Almost everyone I have met so far is affectionate and friendly, which is nice.
>
> Anna told me that there is a book she needs to have photocopied but does not know how she will do it. She thinks that maybe her friend who works at ICAP[100] can help her.

My initial impressions consisted of three things that I found to be the most different from my own limited personal experiences in a doctor's office in Canada. First of all, I was surprised that not once did a patient object to my presence. Most patients assumed that I was a medical student. When told that I was an anthropologist from Canada, they usually became interested in what I was studying; and how I felt about the Cuban health care system. Some people did not really understand why an anthropologist[101] would be studying in a clinic; and continued to believe that I was a medical student, despite my explanations. Many patients, when they would see me on the street, would shout out *"doctora!";* once they had my attention, they would proceed to describe their various aches and pains to me. I usually responded by encouraging them to come by the clinic; they usually did.

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[100] ICAP is an international friendship and solidarity organization known for its strong political ideologies.

[101] Anthropology in Cuba is generally studied as archeology and physical anthropology. Social and cultural anthropology courses are not offered at the University of Havana, and to my knowledge they are not offered at any other university on the island.

Another theme that struck me as unusual was the lack of privacy accorded to patients in the *consulta*. Elderly people were often accompanied by a son or daughter, and many women came with children or grandchildren. Interruptions were frequent. Patients would knock at the door to ask questions, the phone rang incessantly; and technicians, students, and sometimes other doctors or friends of Anna would come by to ask questions or to visit. One technician came in almost everyday to flirt with me and bring me pastries. The interruptions in themselves struck me as unusual, and it was rare for a patient to sit through his or her entire *consulta* without at least one interruption. Furthermore, both doctor and patients rarely discouraged such interruptions; and instead would often stop the *consulta* to chat with the technician, doctor, student, patient, or friend who was interrupting. However, occasionally if it was a particularly busy day, or if Anna was in a hurry to finish her day in order to attend a meeting or to run an errand of some sort, she would become aggravated; and ask some of the people who interrupted to either make an appointment or wait until she was finished with her patients. During school breaks, many of the clinic staff would bring their children with them to work; and the children were often left to roam the halls and offices freely. During these weeks the clinic seemed even more chaotic than usual. In addition the electricity, and even more frequently, the water would often stop for sometimes several hours a day. Despite the constant interruptions, the steady stream of people walking in and out of the *consulta,* and the numerous student observers, patients seemed largely unaffected; and spoke freely about their personal lives, medical problems, and other things that I believe most Canadians would find too personal to share with so many people in such an environment.

Many of my initial observations and perceptions persisted throughout my fieldwork. For example, I wrote the following in my field notes dated January 12 and January 28 respectively:

> I saw two patients getting laser-acupuncture today. Carlos drew the acupuncture points on the woman's legs, and explained to me what they are for. The patient didn't mind that he did this! She didn't protest at all; instead she asked me if I was studying medicine here. I told her no, that I was a medical anthropologist; and she was very interested to know what that was, what I thought of the health care system and of Cuba. She asked a lot of questions about the health care system in Canada. I asked her if the laser-acupuncture hurt; and she said no, but that the first time she tried it, she was very scared. I never cease to be amazed at how co-operative the patients are with me, and how informal the doctor-patient relationship is here.
>
> José wants me to learn how to do acupuncture. Is there an ethical problem with this? He showed me how to do it, and gave me a needle and a cotton pad to practice with. He let me practice on his own arm while one of his patients watched. I broke the needle, and he laughed and told the patient that I would be doing all the acupuncture here starting next week. The patient joked that he would have to find a new doctor because he didn't want to have broken needles stuck in his body. José told me later that within a couple of weeks I really would be ready to insert the needle

into a patient. He is so generous with his knowledge.

Recorded Data

Anna saw patients three times a week for homeopathy and twice a week for physiotherapy. The physiotherapy days were usually busier. I kept records of the age, sex, time spent in the *consulta*, type of illness, and prescribed treatments for a total of 648 doctor-patient encounters. In addition, I recorded any unusual or interesting occurrences during the patient visit. The following tables summarize my recorded observations.[102]

Table 3: Age of Patients

Average Age of All Patients	53.66
Average Age of Physiotherapy Patients	57.63
Average age of Homeopathy Patients	45.79

Table 4: Sex Ratios of Patients

	Male	Female
All Patients	22.76%	77.24%
Physiotherapy Patients	24.63%	75.37%
Homeopathy Patients	19.58%	80.42%

Table 5: Time Spent With Patients

New Physiotherapy Patients	7.43 minutes
Repeat Physiotherapy Patients	7.12 minutes
New Homeopathy Patients	22.08 minutes
Repeat Homeopathy Patients	10.75 minutes

Age of Patients

The youngest patient I saw at the clinic was a baby boy, approximately 10 months old, who had a rash and a cold; and was being treated with homeopathy. The oldest patient was an 89-year-old woman with arthritis in her neck, who was being treated with physiotherapy that included an infra- red light and massage. I asked Anna if she thought that the average age of her patients (53.66) seemed high or low, and why she thought her physiotherapy patients averaged almost 12 years older. She told me that this was simply because older people have more health problems, especially the type that require physiotherapy (the majority were being treated for pain, arthritis, or artrosis). She felt that the average age for her homeopathy patients might also be higher for her than for other doctors because she has worked as a physiotherapist longer than she has worked as a homeopath; many of the patients who know her are older for that reason.

Sex of Patients

Over 77% of patients were women, and the percentage was even higher (over 80%) for homeopathy patients. There are several reasons for such a huge discrepancy in sex. The first and most obvious reason is that the life expectancy in Cuba is higher for women (77) than for men (73) (WHO, 1996). Another reason is that Cuban men tend not to report their

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[102] In a few instances data were not recorded. In such cases they were simply not included in my calculations.

as *machismo*[103], an overstated form of masculinity that places a great deal of pressure and has a great impact on the lived realities of both men and women in Cuba. *Machismo* is a very loaded term, and certainly does not apply to all Cuban men. However, it has created an environment whereby men are not as comfortable admitting they are ill.[104] If they admit to an illness, they will often remain reluctant to seek treatment for fear of being viewed as *debil* (weak). Many Cuban women also told me that in Cuba, women tend to suffer from illnesses because women give birth, which creates certain health problems that men are not exposed to; and because a woman's life in Cuba is more difficult than for a man, since women must often work at a job outside the home, as well as being responsible for most of the household chores such as cooking, cleaning, laundry, and childcare.

Anna told me that another reason that there are more female patients is that health care in Cuba is generally the domain of women. Women are usually responsible for the health and well-being of their families, and so are more sensitive to the subtleties of various illnesses. There is some evidence in the literature that homeopathy is more popular among women in other Latin American cultures as well. For example, Michael Whiteford (1999), after conducting 174 interviews in homeopathic clinics in Oaxaca, Mexico, found that women are more devoted followers of homeopathy than are men; and also better at monitoring and maintaining their health than are men. Men, more than women, preferred the care of an allopathic doctor.

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[103] See Gilmore (1990:4) for a definition.

[104] Even though I worked primarily with Anna, other doctors I worked with appeared to have a significantly higher proportion of female to male patients regardless of the sex of the doctor.

Time Spent With Patients

The amount of time spent with a patient is not accurately reflected in Table IV because I recorded only the time that the patient was actually in Anna's office. Furthermore, people coming in to pick up prescriptions and just leave a quick message that they were felling better were also included in the data. In reality, a physiotherapy patient is examined by Anna, who determines the method and duration of treatment necessary, after which the patient goes to the physiotherapy room and waits his or her turn in the *cola* until the technicians are ready to take him or her through all the exercises that Anna has prescribed as part of the treatment. The exercises and treatments can take anywhere from twenty minutes to two hours, depending on the severity of the patient's problem. Treatments took place every day (Monday to Friday) for between five and fifteen days, after which the patient had to report back to Anna for more treatments or to be pronounced well.

New homeopathic patients took longer because they had to be interviewed. The interview consisted of many questions, beginning with those pertaining to the patient's family and work situation. Questions then centered around the patient's constitution; for example, if they prefer sweet, sour, salty, or spicy foods; if they prefer the winter or summer; nature of bowel movements; etcetera. The next set of questions was related to more specific ailments troubling the individual. Sometimes Anna wrote prescriptions for patients immediately following the interview; and at other times she would have them come back another day, or drop by her home to pick up their prescription so she would have time to review their *historia* before deciding on a medication. When homeopathic patients returned (usually two weeks later), Anna would ask them how they feel on the medication; and question them about the current state of their health. She would then sometimes prescribe a different medication, more of the same medication; or if the patient felt better, she would sometimes stop medication.

Diversity Among Patients

As I expected, in interviewing both doctors and patients, I found a great deal of variety in their opinions and perceptions toward alternative and traditional medicine and medical systems. What I had not expected is just how drastic these differences would be. In most cases, many of the techniques used are by definition 'alternative,' as they operate within the setting of a clinic dominated by biomedical theories and philosophies of medicine; and not as medical systems in themselves. Likewise, many of the people I interviewed saw these alternative treatments as nothing more than 'filler,' albeit usually as effective filler, to replace what biomedicine was lacking, while others had become dedicated followers of these alternatives as 'medical systems,' and sometimes even incorporated the philosophies into their way of life. This dedication sometimes had a dramatic effect on their overall worldviews, conduct, and approach to life.

During my first research visit, when the bulk of my research took place, I conducted lengthy semi-structured interviews with twelve patients (see Appendix I). Here I present some of my findings that I have classified into eight 'types' of patients, according to their reactions and interactions with the health care restructuring. The types are ordered from complete rejection in Type I, to Type VIII, a patient who claims to have had his life transformed by his exposure to alternative medical techniques.

Type I: Humberto, Ideological Rejection

Humberto is a young man in his late twenties, born well after the revolution. He has a certain contempt for the politics of his country; and dreams of moving to Miami, where he believes he will have a better life. In terms of the health care reforms in Cuba, his views are very much like his views on government reforms in every other aspect of Cuban society.

> You know here in Cuba life is very difficult. My father fought for the revolution, and what did it get him? What did it get his family? We cannot even buy a chicken to eat. Everyday we eat rice and beans, and watch the extranjeros eat the chicken and the lobster. They [the extranjeros] stay in our hotels, eat our food, and have our women while me and my family and the Cuban people - we sit at home hungry, and are expected to support La Barba[105] but he does not support us. I want to leave; to go to a country where I at least have a chance to make the life that I want.

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[105] Meaning the beard. This is a name used to refer to Fidel Castro, and is considered derogatory.

> *But do you feel that the revolution has given you anything?*
>
> The revolution has given me hunger and suffering. My parents tell me that it was a good idea, but now? Look around you. You have been here a long time, you live with us, you stay in a Cuban home, you have seen how we must live. You must be tired of the rice and beans too.
>
> *What about the health care system? How do you feel about it?*
>
> Oh, yes, everyone says "but we have free health care and education"; but it is not free. We pay; we pay with our freedom. And now our health care system does not have the medicines or the equipment we need. Last week my little sister was sick; and the doctor said that she needs antibiotics, but the pharmacy does not have any.
>
> *Did the doctor have anything else to offer in place of the antibiotics?*
>
> Oh yes, they gave us *tisane;* but I do not believe in these things; they are just so we won't think things are so bad.
>
> *Can you explain that to me?*
>
> These teas and herbs. Now our doctors are using medicines from before, medicines that people use when they do not have real medicines. This is a step backwards for us, but the government wants us to think that it is good for us.

Humberto is definitely an extreme case. He is angry, and feels that Cuba is no longer *Cuba para los Cubanos* (Cuba for the Cubans). His anger is directed almost solely at the government, and does not see the wider constraints placed on his country's economy as playing much of a role in the current situation in which he lives. His opinions are interesting in that they reflect a lot of the frustration that many Cubans feel today. The fact that Humberto was not alive before the revolution has left him with no grounds for comparison, so he sees his country catering to foreign tourists at the expense of the Cuban people themselves. The Cuban government argues that these are temporary measures, and that eventually Cuba will rebuild its economy and life will improve; but for those who have lived mostly during the Special Period, it is more difficult to maintain faith in the government.

Humberto does not accept the health care reforms because he sees them as just another excuse made by the government to justify substandard provisions. He rejects the reforms on ideological grounds. Since he does not trust the government to do what is right for him and his family, he does not put any faith into the health care restructuring. When I returned to Cuba in December of 1999, Humberto and most of his family had already left for Miami.

Type II: Yolanda, The Reluctant Skeptic

Yolanda is a young woman in her twenties, also born after the revolution. She doubts that *la medicina alternativa y natural* is effective, but does not completely discount it. She prefers *la medicina química* (literally chemical medicine, or biomedicine); and will take alternative treatments only when she has no other choice.

> Alternative medicine? Natural medicine? Oh, I don't know. I suppose for some people it is OK, but for me... well, I

> prefer *la medicina química* because well, that is what works for me. I know that my grandmother, when she was alive, she used to make me teas from different plants; and I just thought that she was, you know, old-fashioned. I never thought that the doctors here would start to use it too; but I guess it is what has to be done because you know the Americans will not let us buy medicines from them, and so we have little choice - it is just too expensive. Sometimes even if we had the money, we can't buy it anyway because of the *bloqueo.*
>
> *Have you ever tried any alternative treatments?*
>
> No. Well, yes, the stuff my grandmother made for me when I was a little girl. But when I go to the doctor I say "please don't give me an herb, give me some real medicine." And they do if they have it, but I don't get sick very often. I am lucky that way.
>
> *Do you think that introducing these alternatives was a good idea?*
>
> I don't know; like I told you, we have no real choice. I think that some people like it. Some people say it is better for you, less aggressive to the body; but maybe that is because it does nothing to the body (laughs). But really, I think that sometimes if you believe something will cure you then it will cure you; it is a placebo, they call it. So, well, I guess it is a good idea. I don't know; the doctors, they know more about it than me; so maybe.... I don't know.

Type III: Maritza, At Home but Not in the Hospital

Maritza was one of the first patients that I interviewed. She is a housewife in her late thirties who claims that she does not 'really' believe in *la medicina tradicional y natural,* at least not in a hospital. She uses some forms of alternative medicine in her home, but does not code it as medicine *per se.*

> *What do you think about the use of alternative and natural medicine in the Cuban health care system?*
>
> Well, I think that I don't really like it. I prefer to use *la medicina química* because I know that it works. This other stuff I do not know about but I think that it is not as effective. Well, maybe for some people; but it is not for me.
>
> *Why do you think it is being used?*
>
> Because we have no other medicines! If we had other medicines, I don't think we would be using this.
>
> *Do you think that if the Special Period were to end, that the doctors would go back to using la medicina quimica exclusively?*
>
> Probably, yes, because it is more effective.
>
> *Do you ever use alternative or traditional medicine?*
>
> No, my brother is a doctor; and he knows that I only like to use *la medicina química.*
>
> *But I have seen you make teas and use acupuncture on your family.*
>
> But that is not medicine; is that what you mean?
>
> *What is it?*
>
> Well, that is just something that my mother taught me [the teas], the acupuncture, well, I guess that they use that in the

> hospital; but my brother taught me that if you press into your hand here (indicates the spot where her thumb and index finger meet), you can maybe cure a headache. But still I do this for my family, not for me.
>
> *These are some of the things that they use in the polyclinic, and many family doctors use them too.*
>
> Yes, well, I think that at home it is OK because if the person is not seriously sick, then you can treat them at home; but if it is serious, they should go to the doctor or the hospital and get real medicine.

After the preceding conversation with Maritza, I decided to make my questions a little more specific by giving examples of alternative, natural, or traditional medicines instead of just referring to these treatments under blanket terminology. Because I was surprised by Maritza's response to my questions, I asked a friend of mine who is a medical professor what he thought about her initial reaction that the teas she made were not considered *medicina natural*. He told me that he was not surprised, because most Cubans do not think of their teas and herbs as being medicine.

Type IV: Alberto, Acceptance... To A Point

Alberto is an older man of approximately 65 years, and in surprisingly good shape for a heavy smoker. Alberto fought in the revolution, and is a revolutionary at heart; he is well educated about Cuba's policies in virtually any area. Alberto's statements are the most common types of responses I received to my questions.

Alberto supports the incorporation of alternative methods of health care; and sees it as a move not just to fill the gaps that a shortage of biomedical drugs has left, but part of a larger, international move toward less aggressive and more sustainable forms of health care delivery. He supports the health care reforms; and uses many forms of alternative treatments, including homeopathy and acupuncture; but argues that there are some things that only biomedicine can deal with. He believes that biomedicine remains both more respected and in stronger demand than any of the available alternatives.

My interview with Alberto is long. We drink many *cafecitas,* and he tells many stories about his life experiences. As I question him, he walks around his apartment (large by Cuban standards), periodically stopping to pick up a bottle of homeopathic remedies that he has taken, in order to show me that he does use this type of medicine.

> *Is there a type of treatment that you prefer? Traditional medicine or...*
>
> The one that solves my problem; it could be anything.
>
> *So it could be traditional medicine or biomedicine?*
>
> It could be anything. Of course, there are diseases that you know. For example, when I had pneumonia, any doctor who would want to treat me with plants or with homeopathy, no, I would say, no. I need penicillin for the pneumonia.

> *So what if they wanted to give you plants to treat the pneumonia?*
>
> As well as the penicillin, fine, OK.
>
> *What if they only give you plants?*
>
> No.
>
> *What would you do?*
>
> I would go to someone else.
>
> *Even if they thought that the plants could cure pneumonia?*
>
> Even if they thought that, no, that kind of thing, no. For example, if I have cancer, I will do whatever because I know there is no cure for cancer; or maybe they say, no, there is a special plant that is the best for cancer, so I say, OK, let's have this special plant. So maybe there is homeopathy for this that is proved to be very good for cancer. OK, let's have it; but with pneumonia I know I need penicillin.

Alberto explains to me that he thinks many alternative medicines are better for prevention and long-term benefits to one's health. Furthermore, he likes the fact that the alternatives to biomedical drugs do not have harmful side effects.

> You know, Tracey, I do prefer many alternative medicines if I know they will help me. If I know that they will serve me the same as the biomedical drug, then I will prefer to take them because I know that they are less aggressive to my body and they will not make me sick in other ways.

> *What about that show we were talking about when they operated on a patient using only acupuncture instead of the anaesthetic? If you were to go into the hospital to have an operation and they said we are not going to use an anesthetic; we are going to use acupuncture. Would you let them?*
>
> Wow! (Laughter) I would try to convince them that I need the anaesthetic. But fine, if they said that you have to have this operation, and the anaesthetic could kill you, and there is a possibility of using acupuncture; well, that is different. If I don't die of a heart attack, terrorized by the idea of them using acupuncture instead of anaesthetic to cut me open! (Laughter) I would die of a heart attack before they cut me!

Alberto is open to using alternative methods of treatment, and in fact often makes use of them; but he has his limitations. In cases where he has been successfully treated with a biomedical drug, or where the efficacy of such a drug is indisputable, he prefers to use that drug.

Type V: Juliana, La Campesina Tradicional

Juliana is a cheerful and friendly thirty-eight-year-old woman who lives with her husband, daughter, mother, and father in a small two-bedroom apartment. She is very knowledgeable about what she calls *medicina verde,* and is very accepting of many other forms of alternative and traditional treatments. She uses many herbs that she grows herself at home to treat herself and her family. As she walks me through her home, she shows me many plants and describes their medicinal properties. We are interrupted frequently by her father, who shouts reminders such as "*Y la salvia, no olvidas la salvia!*" (And the aloe, don't forget the aloe!) She learned about these herbs while growing up in *el campo,* where she tells me herbal traditions are much stronger because, prior to the revolution, medical care was not available in most rural parts of Cuba, so people developed a rich herbal tradition out of necessity. The vast knowledge that she has was passed down to her by her mother, but mainly by her grandmother, who at one time was her town's *yerbera* (herbalist).

> Oh, yes, Tracey, I have been using herbs since before the Special Period. I have always used them. They sometimes talk to the tree and say I am going to take your leaves to make my health better, and it is true!
>
> *Who talked to the trees?*
>
> My grandmother; she talked to the tree; and she said I am going to take one of your leaves for Julianita, to make her leg better. Then she would give me the tea, and tell me not to take the pill because it would hurt me. In the time before, earlier generations knew this because before we did not have doctors for all these things; and so we used green medicine in the house. Everything that worked, well, we kept using it if it worked.

Juliana also takes homeopathic medicine to help mend her broken arm. She tells me that she does not feel that the Special Period has changed very much for her in terms of her health care, and that she just continues to use whatever is available.

> For me, I use natural medicine; but if it doesn't work then I will use the allopathic medicine. I also take my daughter to the doctor if I can not make her better at home, and she goes to the doctor for her check-up every year. My sister-in-law is also a doctor, and when she visits she always makes sure we are not sick; but we never are. It is sad that

> we do not have all the medicines that we need; but I think that the Special Period has taught people a lot about la *medicina verde,* and now people are starting to realize that it works.

Type VI: Enrique, The Faithful Revolutionary

Enrique is a tall and elderly man nearing eighty years. He is a strong believer in the revolution, and vigorously maintains that any decisions made by the Cuban government are done to benefit the Cuban people. He is of African descent, and talks extensively about all that the revolution has done to benefit his *raza* (literally, race). He uses acupuncture to help alleviate his chronic back pain; and tells me that it works well, although sometimes he wishes that pain killers were more plentiful on the island.

> But this is temporary. We must be strong and remain faithful to the revolution. It has given us a lot. Before, my children would not be able to go to the dentist; my grandchildren may get parasites and have to suffer with no help. But since the Triumph of the Revolution, we have free health care; we can go to any kind of doctor and they will help us get better. It is a difficult time, but we must remember all that we have fought for. Communism is a mind set; it is not just a behavior but a way of thinking. Do you understand me?
>
> *Yes, I think so.*
>
> Sure, I wish that I could have pain killers; but at least I can use acupuncture. Before [the revolution] I had nothing, and would have to suffer with no relief. And you know things are getting better. I remember just a few years ago when the Special Period was at its worst, we had very little to eat. And still we have little; but it is getting better and no one is starving, and everyone can go to the doctor, to school;

> everyone has a place to live and something to eat. With every accomplishment there must be some sacrifice, and now is our time to sacrifice.

I found that the opinions and beliefs of Enrique were most common among older Cubans, especially those who had reached adulthood by the time of the revolution forty years ago. They are the ones who experienced a Cuba without many of the social securities that exist today, despite the fact that many of them need much in the way of resources. Cubans of African decent, as well, had the most to gain during the revolution. With the government's policy of *plena igualidad,* all Cubans regardless of gender or ethnic origins were given equal rights.[106]

Type VII: Miriam, La Naturalista

Miriam is approximately fifty years old (although she looks much younger); and runs a *casa particular* which can sleep up to six persons other than herself, giving her access to dollars and making her financially better off than the majority of Cubans. She lives alone, but her son and his family lives near by and visit her often. Miriam is very interested in the movement toward what she calls *la medicina natural*. "Everyone says that I am a *naturalista,* and I think that this is true. I love all things natural - food, medicine; I even prefer to wear clothing made with natural fabrics," she pronounces as she hands me a glass of fresh squeezed guava juice.

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[106] See de la Fuente and Glasco 1997 for a recent survey of racial attitudes in contemporary Cuba.

The fact that Miriam runs a *casa particular* also gives her access to information about other countries, which, in Cuba, is considered a valuable commodity. Many of her visitors tell her stories, and provide her with information about alternative health care practices in their countries; and she questioned me extensively on what types of treatments are available in Canada. She has also received presents from repeat customers who know about her interest in 'all things natural' such as vitamin pills; a wide variety of herbal teas; and her prized possession, a vibrator to massage her back. Miriam, like Juliana, was born and raised as a *campesina;* and believes this is responsible for sparking her interest in 'natural' treatments. She tells me that the two most important things in maintaining one's health are hygiene and proper diet. She defines proper diet as a lot of fruits and vegetables, with small amounts of meat and starches (exactly the reverse of the ideal diet for the majority of Cubans). Miriam feels that allopathic medicine is necessary for performing surgeries, or if there is a life-threatening emergency. But for all other things, she believes that natural medicine is better.

> And the difference in traditional medicine is that it is not commercial; one can get it naturally from our countryside, etcetera. It is very advantageous because it is more accessible to any person; it does not aggravate, because it is not the same thing. If you have an infection, you take some [homeopathic] drops; it is more comfortable. And the effect is quick, because I have used it and it has worked for me and it is more comfortable. For me, traditional medicine in our country, fundamentally it has come to fill a very difficult space, a very difficult thing because here there has been a lot of shortages in medicines; they cost a lot, and

> with traditional medicine therefore it is more.... the patient therefore is closer to obtain their cure, it is more comfortable. Because one can make a treatment in their home and to come to know that one has *medicina verde* (green medicine). It is very important! And it is true that it works, for me. It worked for a hernia, column, in the stomach, also for nerves, only with [homeopathic] drops.

> *And is there enough information about natural medicine?*

> OK, one must have more information on the radio, the newspaper, and the television because there is not a lot of information; but the people are very... they follow traditional medicine a lot, they are very enthusiastic with it, they have a lot of faith. I prefer traditional medicine because it is healthier, more effective, more economical; and it doesn't have contradictions either.

Miriam's fascination with 'natural' medicine is not uncommon. I saw many patients at the clinic who became fascinated with homeopathy, especially when they saw that it worked for them. Of course there were many Cubans whom I met who refused to give up their traditional diet of rice, beans, and pork; and refused to believe that a plant could cure them as well as a pill; but there were still a large number of people who sought out information about the alternative treatments now available to them, and welcomed the change to a medicine that many referred to as *más holistica* (more holistic) or *más sana* (healthier).

Type VIII: Julio, The Transformed

Julio is another young man, but one with a radically different opinion toward alternative and traditional medicine than Humberto. Julio speaks romantically, even poetically, about traditional medicine, especially traditional Chinese medicine; and has been taught about 'ancient Chinese and Indian philosophies' by visiting monks, and through his own personal research. He also practices advanced Yoga and Qi Gong, and is a devout follower of the Buddhist religion that requires him to attend numerous meditation retreats. Julio is a vegetarian (not an easy thing to be in Cuba), and describes himself as a very spiritual person.

> *How would you describe traditional medicine?*
>
> Traditional medicine is for me an extension of the same traditional beliefs or philosophies. In terms of Chinese medicine, for example, the whole system is based on Taoism. It is like the minute you learn to get in touch with nature, the minute you learn to sound in the same accord as nature, you will have no problems and you will always be healthy; and the minute you forget about these things, you will become ill. So what the medical system does is try to reestablish this balance through herbs, through massage. Even if you go back in time, like the Ayurvedic medicine, you realize that they were trying to do the same thing. It was a complex, a very complex system - trying to let you know how to lead your life in a better way. Not just what to eat, OK, these vitamins are good because of da na na na na - No! How to eat those vitamins! How to eat them in the moonlight, how to eat them in the daylight. So they dedicated their whole lives to studying this process inside the body and outside in nature; and so for me traditional medicine is a way of harmony, a way of... yes, that is what it is. It is an extension of the philosophy of which it has based itself.
>
> *What does health mean to you?*

> What is health?... Well, in the early Taoist Medicine Treatise it is written: if you follow yin-yang you'll never get sick. This is the very basis of the traditional Chinese medicine, and you will see this principle in all the ancient healing traditions. All you need to find is balance - in your body, in your mind, in your emotions. In other words, the only effort to make is to get to recognize balance in nature. But balance can be painful at times; like for example, when the earth tries to recover its balance, then we have what we call natural disasters, right? And we all know that an earthquake won't last five minutes; it is just a temporary adjustment. So we should learn to understand that our bodies speak to us through themselves. They keep on telling us about our needs and mistakes; but we don't have the time or patience to listen, do we? So it is easier to take whatever pill than trying to hear through pain. On the other hand, to sit calm and listen to ourselves for a while, when apparently healthy, sounds like a waste of time. I must say that most of the famous healers were very sick men that learned to reestablish the balance of their bodies through the outmost cultivation of attention and perseverance.
>
> *Yes, that makes sense.*
>
> And this is the other thing I want to point out about health: A person that never gets sick; he dies the minute he falls in bed. A person who learns to move in life, even with a tumor or cancer, he will certainly meet his grandchildren. Do you agree with me? Which of these two people is indeed a healthier individual? So health is a very complicated and beautiful word, since it can't be limited to just what we reach to see, but instead it goes beyond our actual perception. A realized being is he who understands that health is the correct apprehension of energy balance in the universe, inside and outside our body- minds. Thus at this level of experience, health is not an object anymore, but the very subject of existence - ever changing, not limited by barriers of logic and what we call understanding. Do you follow? Health? Good question! (laughs).

It is very obvious from Julio's answers that he has a very deep understanding of traditional Chinese medical philosophies. He uses every opportunity he can to learn more about traditional Chinese and Indian ways of life, and he applies these philosophies to his everyday life. In our conversation, Julio commented on the use of such medical practices within the official health care system.

> *Is there a difference between how you understand these traditional Chinese healing practices and the way that they are used within the official Cuban health care system?*
>
> You know, well, you see them talking, you know that they never understand each other. But of course for a person to go to China to study traditional medicine; well, this is very necessary. Let's say in terms of interest, of government interest, it is necessary to send first the doctor because you know they have a title and they will be supported over there. But that is not necessarily a condition for a person to know how to cure another one – you should have interest, you should have sharp, sharp vision, you should have the sort of vision where you can sense the energy and not just talk about it – Qi, Qi, Qi, Qi. You need to sense it, move it, find it in yourself. I mean that is what traditional medicine is – when you go deep inside. But the approach right now is not so holistic; it is more based on what we know; what we know is... OK, this is the cardio-vascular system, this is the nervous system; but they [the traditional Chinese practitioner] never talk about that; they talk about channels, meridians. Where are the meridians? You can't see it, it is not visible; and they never talk about that; they talk about Qi; and if you open up the body you will never see a meridian or Qi flowing - you will see blood. So that is one of the main differences.
>
> *Nicely put.*
>
> Thank you. But it is like the approach is still not traditional enough. I would say that it is too bad, because it doesn't help in terms of really getting to know what is going on there. But still you can find people here who really know the system. But of course most of them are not doctors; they are just simple people who are able to do beautiful,

marvelous things to you, like curing things maybe a doctor with all sorts of titles could never do, because they believe.

So you don't think it is necessary for practitioners to be medical doctors so long as they understand and believe in the traditional system that they are practicing?

What I am trying to say, what is really important, is that people going there or people being taught here need to be really interested in the system; and not just as an extension of western medicine, like a lot of people see it now. Like, OK, we are going to use it when we don't have this and this and this. In China it is different. They use western medicine when they have an emergency because western medicine is good for emergencies; like you have blood, or you have a real problem and you cannot wait; you take a pill and it kills you [the pain] – OK, no more pain. But if you can handle the pain, if you can handle it with natural resources, natural remedies – you don't need to take a pill; nobody is going to take a pill but our tradition is different.

So each system has value.

And I want to add one very important idea here: just as a doctor is not needed to teach you the art of healing, a monk is not necessary either. Again, I insist, what you certainly need is an authentic healer. But the thing is that monks, and I'm talking from my narrow-but-practical experience with Buddhist monks and yogis, develop a very acute sensibility and perception through their systems of practice. This is what you first need to really understand, what so-called health is in the first place. So it is very possible for a well-trained person, trained in terms of attention, concentration, and insight, to really develop certain skills. They call these siddhi in the Hindu tradition. In most cases intellect and formal logic come to disturb the process of attention, because we all tend to rationalize experiences instead of becoming part of them and find our place right inside there. Do you know what I mean? The problem for us westerners is that we keep on looking at health, just as we look at nature, as something we can or can't have, depending on certain conditions. That is, we even consider an object-

> health; and I say WE because we are all conditioned by our doctors, by our science and knowledge.

Julio therefore feels that the official system is trying to use traditional Chinese medicine and other healing systems to satisfy a need within the preexisting biomedical system. He does not feel that this is the right way to use these systems, and that they lose their consistency when practiced in such a way.

It is obvious from the above summaries of patient 'types' that there are a wide variety of opinions toward the health care reforms in Cuba. Patients conceptualize these changes in many different ways, and they have affected the experience of illness in many different ways. Some patients welcome the changes; and even feel that there should be more of a change in order to incorporate traditional and alternative systems instead of just borrowing from their *materia medica,* while others feel cynical and even angry about the reforms. The majority of Cuban patients, however, fall somewhere between these two extremes, passively accepting the reforms with mild interest, or believing that they are a logical solution to their economic problems.

Diversity Among Doctors

Just as there was a great deal of diversity among patient responses to the health care reforms, there was a great deal of diversity in the response of doctors in Cuba to the changes in their health care system. I have classified the doctors whom I interviewed into eight types, ranging from a complete rejection of alternative and traditional medicines, to the complete rejection of biomedicine in favour of alternative and traditional medical systems.

Type I: Hugo, Complete Rejection

Hugo is a middle-aged surgeon, very dedicated to his work in the medical profession. He believes that medicine is a science and should be practiced as such, and that the incorporation of *medicina natural y tradicional* is a way of making the practice of medicine less scientific. He is offended by the suggestion that he use herbal medicines or any other form of alternative medicine.

> And now they ask me to use this backwards medicine? No I won't do it! I am a doctor, not a *curandero!* I have studied medicine in university for many years, and I will not give people herbs instead of real medicine.

During our interview, Hugo seemed very bothered by the subject of my research; and indicated on several occasions his concern that people in Canada may read my thesis and think that Cuban doctors are not real medical professionals.

> Oh my God! People will now know everywhere what a disgrace this has become! They will think that we are a bunch of uneducated *campesinos* instead of educated medical professionals. Oh my God! I don't use these things. Write that not everyone here is superstitious. Many of us still practice real medicine.

Hugo goes beyond refusing to use alternative treatments, and claims that their incorporation has had a negative effect on the level of education medical students now receive.

> The curriculum before, in the 1970s and the 1980s, was much better than it is today – the curriculum has changed. I studied so much science when I was in school, and now we study *communitario*. For previous generations of doctors, it used to be so much harder and deeper.

His solution?

> Money! This is the most important thing. I don't believe in private medicine; but this health care system is very expensive, and we need more money. Also we need resources and better organization, but most of all we just need money...The special period is huge- tomorrow I can't operate on the 17 people scheduled for an operation because I don't have the bandage to cover the wounds after the operations. I operate three times a week, and when there are shortages people always need to wait. We need many things.

Type II: Juan, Tolerant

Juan, like Hugo, is a middle-aged surgeon who believes that Cuba would not be using *la medicina natural y tradicional* if it were not for the current economic crisis. While he believes that these treatments work for some things to an acceptable degree, he still believes that biomedicine is almost always a superior form of treatment. Juan tells me that he does not use traditional or natural medical treatments because he is a surgeon; and when we discuss the use of acupuncture instead of anesthetic, he tells me he would never use it because he has difficulty accepting that it is a legitimate way to anaesthetize a patient, despite the fact that he has seen it done on television. Nonetheless, Juan seems to be well-educated on the various techniques of traditional and natural medicine; and claims that he is more accepting of it now than he was before their introduction into the Cuban medical system. He tells me that the more he learns about *la medicina tradicional y natural,* the more acceptable it becomes.

Juan did not want me to record our interview, but allowed me to take notes. When I asked him to explain what he thought the difference was between biomedicine (which he referred to as occidental medicine) and traditional medicine, he told me that occidental medicine is very allopathic because it treats the illness, germ, bacteria, or virus, whereas traditional medicine treats the sick person. He uses the example of asthma. In occidental medicine all asthmatics are treated the same; whereas in traditional medicine there are many kinds of asthma, and all must be treated individually. He leans over my note pad and scribbles *En la medicina tradicional existen enfermos, no enfermedades*.[107]

Juan uses the word *ofensivo* (offensive) to describe those doctors who he claims are *fanaticos* in their support of alternative medical treatments. He gives me an example of one colleague of his who believes that cancer can be cured with an herbal concoction. Juan feels that this doctor will only raise the hopes of his patients, and prevent them from seeking out scientifically-proven treatments. His colleague, he reassures me, cannot administer such a concoction to his patients in the hospital, where only treatments that 'pass the scientific method' can be used.

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[107] In traditional medicine, there are sick people, not illnesses.

I was curious as to how Juan, who on my first impression appeared to be largely uninterested in the use of alternative medical treatments, had learned about it. Juan tells me that he has gained most of his information from his ex-wife, who is a devout believer in *la medicina natural* and uses it on their two daughters regularly; but he also studies 'a little' on his own. I asked him if he had known very much about Cuba's tradition of *medicina verde* before the Special Period, when it became a commonplace practice in clinics and hospitals. Juan told me that these traditions have been passed down from generation to generation, and their value comes from the fact that many people have watched and learned how to use them. However, he believes that much of it is based on the power of suggestion and silly superstitions, and stories that parents tell their children. For example, Juan tells me that *ojos de pescado*[108] are cured by suggestion. Many parents tell their children to take a handful of corn and walk to the corner and throw it away, and then run as fast as they can in the opposite direction; and their *ojos* will go away. "It really works! I have seen this work many times," he exclaimed. Juan says that treatments beyond the common household treatments, such as the remedy described to treat *ojos de pescado*, or the administering of herbal teas by mothers to their children, used to be practiced by *curanderos sin conocimientos* (healers with no knowledge); but today these treatments are being put to the test of the scientific method; and those treatments that pass, he says, he will have faith in.

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[108] Literally, fish eyes. This is a type of skin rash that is common among children.

Type III: William and Sheila, The Disinterested

William and Sheila are a married couple in their early forties who met in medical school. William is a dentist and Chela is a dermatologist. They are largely uninterested in the incorporation of *la medicina natural y tradicional,* as they do not feel it has made any real change in the way they practice medicine.

> Really *Teresita*[109], even before, I sometimes told my patients to use chamomile or guava for skin problems; and I sometimes still do. I just recommend whatever I think will be the best, but I don't think that I really use it more. I trust chamomile and guava because I have seen that they work - is this what you want to know?
>
> *Yes, thank you. What about you, William?*
>
> Well, I too have not really changed...umm... I think that this is not so much affecting me maybe because I really, I am not working so much anymore because of my health problems, you know; but I wish I was working more. I miss my *consulta* sometimes.
>
> *When you are at work, do you use any natural medicines? Do you think you use them more now than before?*

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[109] Many people referred to me as Teresa or Teresita, the diminutive form of Teresa, as it was easier to pronounce in Spanish than Tracey. The diminutive is often added in Spanish as a form of affection, and means little or dear.

> Well, I have not noticed much of a difference. What I have noticed is that it is hard to get medicines sometimes; the pharmacy does not always have them, but you already know that - it is *el bloqueo*. That is why we cannot get our medicines. That is the biggest difference I have in my *consulta*... the patients complain that they cannot get their medicine.

William and Sheila repeatedly directed the conversation away from the Cuban health care system by asking me questions about health care in Canada, and what I was studying. They seemed very interested in anthropology and the lifestyles of Canadians, but not very interested in discussing the changes to Cuba's health care system. Overall, they both felt that, other than a shortage of medicines and some needed equipment, the way in which they practiced medicine in Cuba has changed very little since the commencement of the Special Period. They both blamed *el bloqueo* for Cuba's current economic situation; but also felt that it affected them less than others, since William's sister lives in Spain and sends them money on a regular basis.

Type IV: Roxanna, Believes In The Medicine but Not its Future

Roxanna is a homeopathic doctor who believes very strongly in its efficacy. She has done a specialization in traditional and natural medicine, but focused on homeopathy. She proudly lists the doctors from numerous countries that she has taken courses from, including Spain, Argentina, Italy, and Mexico. She feels that the ministry of health is not doing enough to promote homeopathy or other forms of alternative or natural medicine.

Roxanna is the only person whom I interviewed who believes that should the Special Period end, Cuba will not likely continue to use the alternatives now present in the official system. But she thinks this is a mistake. Homeopathy, in particular, she believes, is a worthy and valuable system of healing; and should not be used only to fill in the gaps of biomedicine left by the current economic situation.

> Suppose that the government and the state, what they want is to put traditional medicine at every level, for the advantages it has, do you understand me? It is more beneficial because it costs less, because it does not harm the patients. It is a strategy that still needs a lot of development. It can do what an aspirin can; but because of the cultural level of the population, they don't understand this medicine; and they are not in agreement because they do not know, because it has not been given the publicity that it should be given; and so the real worth that it has is not known. Here they use it because of the Special Period; but in all other countries they use it because it is a less harmful method, and because the people like it. But here we only use it because it is cheaper, because the state sees a *camino* (way or path). The people use it because there is not this, there is not the other, because of the Special Period, you understand? But this is only here because of this; in all other countries there is an increase [in use] of traditional medicine in the last few years. And here, in my opinion, it has had a rise [in use] in the last few years because of the Special Period; it has not had too much support from the government.
>
> *And you think that if the Special Period will end, the...*
>
> No, I believe that no, because there already is, since there are many people who don't have any idea of what homeopathy is, of what traditional medicine is. Yes, there are other people that know it and those that like it; and they will stay [with this type of treatment]; do you understand me? Those that like it stay, and they will want [medical] attention. I don't think that it has yet been established, and

they are not going to stop paying attention to it now. I believe that it is a smart thing because of the advantages it has. And still there are not the conditions for traditional medicine, still there are not the conditions and we demand so much, and there are still no conditions for what is required. But in my opinion, the doctors that use this [traditional medicine] are using it with their soul and because they like it, despite that there are not the conditions in many places. I don't have anything to do with the politicians here, here in the clinic, because imagine, there are some places that have the conditions to build and others do not. Some are spectacular and are better equipped, and this influences the service that you will give the patient. This is psychologically important. The patients like to go to an agreeable place. It is not only the doctor's treatment, and whether or not you have the needle, the prescriptions to prescribe; it is not only this, it is the surroundings, the environment, that is very important.

What do your patients think about this?

Now people accept it more; but there are many people that still do not have the mentality, and many doctors still do not accept traditional medicine; and what is more than this is that they do not have ethics either. They do not have medical ethics to treat the patients when they go to ask them for advice and want to be treated with traditional medicine; and they do not have any ethics to say to them no, this doesn't work, with this you will not resolve [your problem]; still there exists these cases.

And why do you think that this is?

Because they don't know the benefits, they don't know what it is; but what is important is that other doctors say this, you understand? Because you cannot go to the doctor... and for example if I say to the patient, "what did the doctor tell you?" And you tell me [what he or she said], and I say "no, no such thing [is true]." Well, I would be a fool to tell you such things because then if you see that doctor again you will not trust them – this is interference, and it is an ethical problem that shows a lack of respect for one's colleagues. This is a problem because there are many

> doctors who still do not understand; but fine, I believe that with respect, when it begins, it will advance information significantly.

Roxanna sees the problem in using homeopathy and other alternative medical practices as being rooted in the lack of support they receive from the state, as well as a conflict between practitioners of alternative medicine and those of her colleagues who do not believe that the alternatives are as effective. She has a great deal of respect for, and believes very strongly in, the efficacy of homeopathy; and perceives the lack of respect by the state and some of her colleagues as an ethical problem that permeates the system in which it is practiced. For Roxanna, the only way to improve the situation is to increase awareness and support for the alternatives, beginning with the Ministry of Health itself.

Type V: Marcos, The Sympathetic Capitalist

When I met Marcos at his suburban home, we sat in his beautiful garden filled with beautiful plants and flowers. When I try to think of a word to describe Marcos, I think of words like peaceful and tranquil; he seems to be genuinely at peace with himself and his life. He is approximately seventy-five years old, in good shape, with a hypnotic voice and a warm smile. Judging by his home and the amenities within it, he seems to be enjoying a high standard of living in comparison with most other Cubans.

Marcos is different from the majority of the Cuban doctors I have met because he was granted his license to practice medicine before the revolution. This means that he can legally hold a private practice out of his home, the reason being that the revolution did not provide him with his education, and therefore it was not necessary to provide his services in entirety to the state. Marcos did, however, carry out his revolutionary duties, working for almost thirty- five years as an oncologist in one of Cuba's largest hospitals. Today, retired from working for the state, he continues to see patients at his home, treating them mainly with herbal medicines that he grows himself in his own garden.

It is difficult to think of Marcos as a capitalist, since he tells me that some of his patients cannot afford to pay him but he will usually see them anyway. He describes his private practice as "more of a hobby than anything else." He wishes to continue practicing medicine, as he believes it is what he was meant to do. By working at home, he can control his workload and still enjoy his retirement, spending time with his family. Family is very important to Marcos, as he sees the family as providing the foundation for good health.

> You know the mental aspects, the psychological, is just as important in maintaining one's health as is the physical. If one does not have the love and support of a good family, how can one be healthy? Everything is harder if you do not have a good family to love you and to help to take care of you.

Are these factors addressed differently in natural medicine than biomedicine?

Certainly, but not just that... the doctor must be aware of the social situation of the patient. If a patient comes to me, I want to know about how they live and if they are happy. You need to be happy to be healthy, no? It is logical that if a person is stressed, depressed, has problems at home, then this will manifest as an illness. In natural medicine the person tends to be looked at more holistically, but this is really up to the perspective of the doctor. The doctor must recognize this regardless of what type of medicine he uses. I prefer to use natural medicines because they do not harm, and I can grow them here at my home; and I see results with my patients. But I do not just want to say to my patient, "Oh you have this? Take this and it will resolve your problem." I want to know why they are sick, and get to the root of the problem. Otherwise you are just hiding the problem, covering it up.

What do you think are some of the biggest challenges to Cuban people's health today?

Well, I think that obesity is a huge problem here. If you are obese you will always have physical problems; and those problems will affect you mentally as well, because you may feel tired and lazy if you are too fat, and you may not be able to move about as you can if you are at a healthier weight. I tell my patients who are obese that they are committing suicide. It is the same thing as running a red light or jumping in front of a train. You are taking great risk if you allow yourself to become obese. Before this was a bigger problem in Cuba. You used to see many obese people on the street; but today we still have this problem, but not as much because times are more difficult. Now we are faced with many problems that cause a lot of psychological stress. Families are worried about how to get food, and how to get all the things that they need; and life is just harder for us now. But we must remain optimistic. You know optimism should be a medicine too.

Marcos currently works as a doctor, largely outside of the system; but he is far from unaffected by it. He, as well as his patients, are living in contemporary Cuba; and must deal with all of the socio-economic problems that exist. All of these factors affect and influence one's state of health. Marcos is well aware of this; moreover, he deals with this in his practice. Despite his recognition of the social and economic problems in contemporary Cuba, Marcos remains optimistic; and does the best that he can to raise the spirits of his patients, and encourage them to build and maintain strong family relations.

Marcos showed me around his garden, and gave me numerous examples of what each of his plants can treat. Every so often he stopped and reminded me that any of these plants will work best if the patient has a loving and supportive environment. When I left, he took my hand and told me not to forget that family is the most important thing in life; and that when I have a family of my own, I should put it before everything, including my work, no matter how fulfilling I believe it to be. This is what he has done, and this is why he is a healthy and happy elderly man.

Type VI, Blanca, The Politician[110]

Blanca is a very political woman. She is a doctor with a specialization in neurology; and works mainly with patients who have Parkinson's disease, spinal cord injuries, Alzheimer's disease, neuromuscular disorders, multiple sclerosis, and brain trauma. She works in the holistic medicine department of a large research centre outside the city; and is very dedicated to her work, devoting more than sixty hours a week to her occupation. Blanca has very strong views on alternative medical practices, and believes that the differentiation should not be between *medicina alternativa* and *medicina alopatica* but between holistic medicine and allopathic medicine.

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[110] This interview was conducted in English.

> Holistic medicine comes from a different conception of the world; and the man integrates that world, inputs into that world. There is a different view of reality, a different angle. Of course every phenomenon is holistic, whether you like it or not. Now if you are speaking of human conceptions of reality, you know that you can accept it. Reality is holistic; and whether you like it or not, we are all part of the universe, and we move with the universe.
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> *Could you tell me more about what is included in holistic medicine, and how you use it?*
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> It is Indian medicine, Chinese medicine, homeopathy, classical homeopathy, because not only do they have a westernized and twisted homeopathy which is an allopathic exercise or use of homeopathy – it seems a paradox but it is real. If you use a homeopathic remedy for the flu, you are not doing homeopathy. You are doing, you are substituting this aspirin for this homeopathic remedy; but what you are using is an allopathic conception. And now it is very, very, very frequent to see homeopathic doctors use homeopathic remedies with an allopathic conception. This is common; and it is not bad, but it is not holistic either. Chinese medicine, for example, does not substitute one thing for another. We are working in a combination of flower remedies, homeopathy, and Chinese medicine, not according to the experience of the doctor but according to the essence of the diagnosis and of the patient. We have not finished but we have been getting closer and closer, and that has been possible only thanks to the models and

qualities of Chinese medicines. So that is what we do in our department; we work with the patient using Chinese medicine as the spinal cord of the, of the uh, treatment; and we also combine that with Bach Flower remedies and homeopathy.

Do you ever use these things in an allopathic way?

Well, yes, there is some; but you can't ah… For instance, for vaginal infections you can use, for instance, garlic juice; and that is good for when you have a, when you are hurt. You can use honey or brown sugar, and it is excellent. You can protect yourself from infections that will cure faster, and I don't want to seem like I am the enemy of that. I just want to point out the difference of what is a holistic approach. And then you have certain practical things; but really it is better when you treat the person, and you put the person into their balance; then the illness disappears. Of course, if that person has a chronic, incurable imbalance, then you have to do different things. Say we have someone with diabetes or something like that. Although it is theoretical, theoretically your goal is to put the person into balance. But in a certain situation where you cannot do what you want to do, then you have to look for different approaches. Or even in the case if you have depression that is a cause of a manic depressive disease, and I'm not speaking about that because with the manic depressive disease you have an altered short branch of the X-chromosome. And then there is something different; and you have to use drugs and you have to use acupuncture; and to use drugs when the person is in-between crisis, the drugs are not bad.

Is it ever bad to use drugs?

The bad thing about drugs is not the use but the abuse of drugs. Most drugs are something that science has conquered. You don't have to fight against antibiotics or... Now that is something that we have that we have to use in the proper amount, as little as possible; and when you do need it you don't need it; you use acupuncture and different things, etcetera. The problem is the abuse of things. Now you see that for anything they use a fourth generation antibiotic, for a very simple thing – for tonsillitis. Why? You can cure tonsillitis without antibiotics; then that should be the first option – you can cure tonsillitis with acupuncture. If the person is not in the condition that their body can ingest the microbe, you can then use a small amount of antibiotics to help the body to prolong that battle. The drug is something that you put in the middle to help when you cannot help without the drug. I think we should take that approach with medicine; because sometimes people who use holistic medicine use it because they feel, they are the enemies of drugs. Why? You should not be enemy of something that has nothing to do with the problem, It is not the molecule of drug but the money-making machine - that is the thing that twists the real essence of medicine. When you go backwards until the beginning of the last century, the doctors did not earn a salary, they did not charge, you paid the doctor an honorium. Do you know what that is?

What is it?

In the classical conception, at least in Spanish, perhaps in English it has a different word, but in Spanish *honorario* is what you pay to the priest when he baptizes your son. If you have a lot of money you pay a lot; if you have a little, you pay a little; if you don't have, he won't deny you the baptism. And the other meaning is dealing with the word *gage* – G-A-G-E – *gage* in Spanish. A *gage* was a certain amount of money that the prince and the king gave to the people that were around him in gratitude for the favour of helping and being faithful to him. So *honorario* is something that you pay for that. What the doctor does, that has no price. After that time medicine became more and more involved in monetary, mercantile relations, and healing became a service; and so little by little you have less difference between a hairdresser and a doctor; if the operation is this long it costs this much, if it is smaller it costs less, or more, it depends. If my name is a very important name, I will charge you a lot; but if my name is not an important name… and then there is something very curious, and I want to think about this with you. That man goes on Sunday to the church because he is a Christian – do you deny him Christ? Does San Lazaro[111] say "if you don't

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[111] In Cuba, San Lazaro is the Catholic saint associated with healing.

> pay I won't heal you"? That is what we do when you transform healing into merchandise. Of course doctors are not guilty of this. Doctors are also victims because that is a consequence of a socially determined, very complicated, economical and social relationship. In my opinion, the sin is to transform medicine into merchandise; and that is not a consequence of a way of thinking of doctors but a consequence of the evolution of a society that is more and more faithful only to the laws of the market. That is the problem, not the drug.

Blanca is not only very dedicated to her work but she is obviously very well-informed and well-educated, not just in the therapeutics of alternative medical systems but in their philosophies as well. The most interesting thing to me about Blanca is the fact that while she is a well known and recognized political leader who speaks often about the virtues of the revolution, and of being a dedicated follower through the practice of medicine, she advocates and makes strong attempts to use alternative medical systems as *systems*. She does not, as do many other MINSAP workers, simply advocate the use of alternatives to fill a need within the biomedical paradigm. In fact, Blanca's practice of medicine is quite a radical departure from biomedical theories of treatment. My interview with Blanca caused me to rethink seriously the boundaries that I had believed to have been established by the Ministry of Health concerning the practice of alternative medicine. *The boundaries within the organization are more flexible than I had originally anticipated.*

Type VII: Lazaro, Integration

Lazaro is a young *medico de la familia* in his mid-twenties. He eventually wants to specialize in *la medicina tradicional y natural,* but in the meantime he makes use of various alternative therapies while working as a family doctor in a newly opened clinic that specializes in traditional Chinese therapies. Lazaro is very serious about traditional Chinese medicine, and says he was first introduced to traditional and natural medicine as a young boy by his father. At the time, Lazaro did not take alternative medical practices seriously, and thought his father was just old-fashioned and superstitious; but he says that he now regrets having had this attitude, and wishes that he had made more use of his father's knowledge when he had the chance.[112] Lazaro spends much of his free time studying the few books available to him on traditional Chinese medicine, trying to learn Chinese, and practicing *Qi Gong* three or four times a week. In addition to providing medical services, he gives *Qi Gong* lessons to his patients in the park three evenings per week. I attended several of these lessons with three to five elderly Cuban patients. I asked Lazaro if he felt the practice of traditional and natural medicine in Cuba differs from its practice in other countries:

> Yes, it differs because here in Cuba most of the people working in traditional medicine were working as allopathic doctors, and that is one of the main differences. Many people working with traditional medicine are orthopods or

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[112] His father now suffers from Alzheimer's disease.

psychologists. And another difference is now we are learning it in university. And another difference is that there is not such a confrontation with the people that practice traditional medicine and the people that practice allopathic medicine; there is not confrontation; there is co-operation. When the people who are doing allopathic medicine see that they cannot solve the problem, they call us, "hey you, come here, we would like you to help us in doing this!" In all the hospitals there is a department of traditional medicine, and the staff there work together with the surgeons, with the orthopods; and they work together; there is no competition. Perhaps the difference is that traditional medicine here also uses allopathic medicine in their diagnostic procedures. Sometimes we mix treatments but with care; we don't take away the patient's medication... we don't say to the patient, "you can't take this allopathic medicine." We just try to diminish the dose, and we keep the treatments because we know that we can't do that. We are intelligent with the patients. Sometimes the treatment might be damaging the patient, but we are not allowed to do that; and we talk to the family doctor and to the specialist, and see if we can do something together. So I think that is the main difference.

Do you have an example, like a specific example of somebody...

For example, we are doing work with arthritis; and people used to have rehabilitation treatments with an analgesic; and we put our treatment, but most of the time it doesn't solve it. And so we quit that treatment; and we say to the patient, OK, let's see how we are doing. And so after four or five days of treatment, we start diminishing the medicine of the anesthetic; and we say to the patient, OK, now you kept that treatment, you don't take this, and now we are going to treat you for the side-effects. This is an example of how we mix the treatments. We have to use the diagnostic procedures from allopathic medicine. There is no other way because allopathic medicine has a very good ability in diagnostics.

Lazaro feels that while *la medicina tradicional y natural* is a good and worthwhile alternative, there is still a definite place for allopathic medicine as well, particularly in the area of diagnostics. By using the two systems together, he believes that the Cuban medical system can provide its patients with the best possible care. Furthermore, he does not see any conflict in using different medical practices together. Rather, unlike Roxanna (Type IV), he feels that the majority of the doctors within Cuba's medical community are mutually supportive of each other's treatment methods.

> *In Canada traditional medicine and conventional medicine are kept separate; they seldom work together. How do you think it is possible for them to work together here?*
>
> Because the way, it is because the government allows it – that is why; and we have the research. And there has always been a spirit of co-operation between Cuban doctors and that spirit of co-operation is here; there is not that spirit in other places. We have a spirit of companionship; we don't try to hide information. Those are the very reasons we tend to be, how do you say? *Solidaridos.*

He also feels that there should be more cooperation among medical professionals in other countries; and that through the exchange of information, different countries can mutually benefit.

> *Is there anything that you want to add, or are there any questions that you have for me?*
>
> Just to say that I am happy that you are going to tell the world what we are doing here, what we are fighting for – keeping good health and improving the health of our

> people. We are trying to do it the best way possible by trying to learn the best way possible; that is what we are doing, trying to learn the best way possible. And we would like to exchange information and know what your doctors are doing, to exchange information and know how. We would like to see that happen because it can only help everyone to share information, no? The more people you have working on a problem, the better the solution will be.

I spent some time in Lazaro's clinic, mainly when he treated one patient in particular, Benny, a ninety-three-year-old man whom I befriended, who suffers from chronic back pain. Benny permitted me to accompany him on his visits over a two-month period. Lazaro treated Benny with moxibustion and electromagnetic therapy. Lazaro would pass the moxibustion stick around the top of Benny's head, moving back toward his neck (where he told me the meridians start) and around both of his knees (which he said moves his intestines and in turn acts to relieve pain). The electromagnetic therapy consisted of a small machine with electrodes that he hooked up to various parts of Benny's body. The machine delivers a mild electric current that starts and alters the *Qi* energy in one's body. Both Benny and his primary care giver and granddaughter, Ina, were very pleased with the treatment program. Benny told me after every treatment that his pain felt less and less intense with each visit, and that he really liked Lazaro because he felt that he truly cared for his well-being.

While treating Benny, Lazaro would tell me about the various advantages of using moxibustion. For example, he told me that moxibustion is a very good treatment for appendicitis; and that it is widely used in China to treat this problem. I asked him if he ever treated a patient with appendicitis this way, and he told me that he had not. He said he had a patient just the other week who suffered from appendicitis, but that he sent her to the hospital. "No one will take the chance in Cuba even though it is used in China, and it has been scientifically proven." I found this statement very interesting because it indicates that there are limitations concerning the use of alternative treatments by Cuban doctors and patients. The statement also indicates the allopathic mindset, due to a long tradition of biomedical training, of many Cuban doctors.

Type VIII: Pedro, The Dedicated

Pedro is a young man in his early thirties who is very serious about taking a holistic approach to the use of what he calls *la medicina tradicional china*. He sees traditional Chinese medicine (TCM) as a complete system that cannot be separated from one's way of life. He has taken a two-year program in acupuncture with visiting Chinese doctors, and continues to work with them even now. He says he is lucky to be working with the University of Beijing because this gives him more access to information about TCM. He tells me that there are two ways to study traditional Chinese medicine (TCM):

> First you have the Ministry way. They use 'scientific' means to study and use this. The second way is using the Chinese philosophy and understanding, using the five elements and using *Yin, Yang* and *Qi.* If you study in this first way, the way that the Ministry studies it, you will

> always have many contradictions, because if you want to use *la medicina china* you must also accept its, its... philosophy. If you don't accept the philosophy behind it, you will always have contradictions; but the philosophy will give you the base and no contradictions in actual practice.
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> In Cuba traditional medicine is being used for different reasons than elsewhere - it is not for a philosophical alternative but as an economic alternative. In 1979 Cuba brought Chinese doctors over to teach traditional Chinese medicine as a cheap medical practice for the Ministry of Defense, to be used in combat when other medical alternatives are not available. They taught this to military doctors to prepare them for use in a military situation. It was practical, not philosophical.

Pedro is aware that traditional and alternative medical practices within the Cuban medical system are used to fill the preexisting biomedical paradigm. He, however, chooses to operate outside of these parameters, trying as hard as he can to use TCM the way that he believes it is intended to be used.

Pedro takes his own words very seriously. He speaks Mandarin fluently, has studied under many Chinese doctors, and reads every book on Chinese philosophy that he can find. In his own *consulta* he uses TCM not only for its treatments and techniques but also in his diagnosis. Pedro tells me that in order to help others, one must have equilibrium in one's own body. He gains this equilibrium by practicing *Tai Chi* every morning at six, does *Qi Gong* three times a week, and follows a strict diet. He has patients three times a week in the mornings, and the rest of his time is dedicated to research and study. "My work is my life," he told me with a smile, and I believe it. I spent a good deal of time in Pedro's *consulta,* and was very impressed with the amount of time and attention he gave each patient.

Pedro, unlike Lazaro, feels that using TCM is a better way to diagnose his patients. He tells me that in order to make a good diagnosis you need to account for the mind, and that western science is too influenced by Cartesian philosophy to do this.

> If you mix that Taoist way of learning and the Taoist conception of life that stands up with the phrase 'going to the origin,' which means respecting the past. You have at least five thousand years of knowledge accumulated, organized, etcetera through the holistic conception and that is why I think that it is not a mistake to take the Chinese medicine as the spinal cord of holistic work; and so I use it here. The second reason is that when you do a Chinese diagnosis, it is a personal diagnosis. You do not have diseases in Chinese medicine; you have different classifications of the general imbalance of the body, in order to help the doctor to know what is the problem of that person. But they do not have diseases. So when you get to work with the type of imbalance the person has, you can use coordinate herbs, acupuncture, massage, chiropractic adjustment with a very complete plan without any contradictions. And say I am going to achieve this goal with exercise, and this with that, and this with that, and herbs with acupuncture, and this with something else, and you make a holistic program.

Pedro also tells me that traditional and alternative medical systems are cheaper, are more accessible and sustainable, have the same effectiveness, and most importantly, are more ecological in that they do not separate the individual and his or her environment. Pedro also tells me that he takes elements of the Chinese culture and applies them to his everyday life, but that he also holds on to his own personality so as not to lose his Cuban identity.

While the majority of both Cuban patients and doctors experience a similar social situation and are behaviourally constrained by similar geo-political and economic factors, there remains a wide range of opinion, thought, and reaction toward the health care restructuring that has not only influenced and affected their treatment-seeking behaviours and explanatory models of illness, but has also, in some cases, changed their overall approach to life and general lifestyle.

Social Change and the Health of Patients and Health Care Delivery in The Special Period

Since the entire duration of my fieldwork occurred during the Special Period, I must rely on my observations of the medical encounter during this particular time in Cuba's economic and political history. As already mentioned, there has been very little ethnographic work done on Cuba; therefore, most of my information about pre-Special Period Cuba comes from stories and accounts told to me by the Cubans whom I knew and met.[113] The World Health Organization, UNICEF, PAHO, and other international monitors of health care indicators all show little change in Cuba's health care indicators within the Special Period; and yet it is impossible to have such an extreme economic recession without some changes in health care needs, concerns, and perceptions. To ascertain how things have changed in terms of health for the Cuban people since better economic times, that is, before the fall of the Soviet Union, I asked patients if they thought that there had been changes in their medical needs, new challenges encountered in trying to maintain their health, and changes in the type/format of treatment received. Most patients felt that there had been changes; and referred mainly to the increased stress of living, with shortages in food, electricity, gasoline, medicines, water, and transportation. Most patients maintained that the one thing that had not changed was that their health care system remained free of charge. The most optimistic patients felt the system had become more flexible with the introduction of *medicinas alternativas y naturales*.

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[113] Mona Rosendahl's (1997) ethnography details life in pre-Special Period Cuba in a rural town somewhere in the Eastern part of Cuba.

There are many challenges facing the average Cuban who is trying to remain healthy. I made the following table (Table 6) that lists the most common factors, given by the Cubans I spoke with, that work for and against staying healthy in the Special Period.

Doctors in Cuba, like their patients, are not unaffected by the conditions of the Special Period. While the introduction and widespread use of alternative medical practices have made it easier for some to continue to practice medicine in Cuba, other factors have had a detrimental effect. The following table (Table 7) summarizes what many of the doctors I interviewed felt are some of the factors working for the health care system, as well as those that have been detrimental to the health care system.

Table 6: Factors Affecting the Health of Patients in Post-Soviet Cuba

Factors Working For Health	Factors Working Against Health
Free health care system	Stress/Frustration
Cheap medications (when available)	Poor diet
Flexible system	Poverty
Strong emphasis on Primary care	Lack of medications
Family doctor on every block	Housing shortage
Strong social networks (friends, family)	Feelings of "no control"
Free education	Lost family members (leaving the country)
	Apagones/Water shortages
	Poor hygienic state of hospitals and clinics
	Lack of hard currency and adequate salaries
	Poor transportation
	Longer *colas* (lineups)
	Increased social problems (drinking, theft, prostitution, drugs, etc...)

Table 7: Factors Affecting Health Care Delivery in Post-Soviet Cuba

Factors Working For Delivery	Factors Working Against Delivery
High government priority	Low morale
Free medical training	Low salary
Flexible and adaptable system	Outdated or irreparable equipment
System infrastructure	Limited access to needed materials
Introduction of alternatives	The problems facing patients in Table 6

Most of the factors supportive of good health are factors that existed before the Special Period, while the majority of the factors working against good health are products of the Special Period, at least to some extent.

In an interview with Selena, a Cuban friend of mine, she expressed her concerns about how the Special Period has made it more difficult for people to remain healthy. Selena mentions most of the factors listed in Table 6, including stress/frustration, diet, poverty, lack of medications, feelings of 'no control,' longer *colas*, housing shortage, and transportation:

> And that is one side, the wrong habits in meals. On the other side there is stress from the psychological point of view, because it is bad for our health because it helps to increase... For example, people have high blood pressure and many other things; and I think that people know very little about the dangers of high blood pressure, and it is important that people know. One of these dangers is stress; and we are living with so much stress now and over the last few years and so now, there are so many people who have high blood pressure. They didn't have it before but they have it now.
>
> *From before, do you mean before the special period or...*
>
> Yes, of course. Because we are in a very difficult political situation, life is difficult, everything is difficult; and we have to face many, many things. We have to be able to face many things in life, in everyday life; and not everyone can do it, and most people have stress. Most people have a lot of hard work; and so they are psychologically unbalanced, and that is another cause of stress. People are very anxious because they have to think about many things that are in our everyday lives; and they are not easy, but they are so necessary that you can't forget them. You are thinking that you have to go to the *bodeca* to see what they are selling, and sometimes you have to go many times and the lines are so long! I have so many things to get there too because you know I have so many people living here. I want my son to get his own apartment, but... you already know. Everything is difficult; and when people don't have enough money, they have to invent how to get it; and that is a problem, and this is bad for health.

So there is more worrying for things?

Yes, and there is also a psychological problem that is not exactly stress, but it is a psychological problem. For example many people are disappointed and they feel frustrated about many things that have to do with their work and with their everyday life, with what they are, what they want to be, with money and all of that. Many people, for example, some are working already; but they don't feel welcome at work because there are so many difficulties even for doctors. And the retirement salary that they have is not enough, and so we have to invent to get more to be able to afford all the expenses of life; and that is bad for health, of course.

So what would you say are the main things that have changed since the special period in terms of health? Like what is different today from fifteen years ago, and how do those differences affect health?

I think that the most important thing is the shortage of medicine because sometimes you go to see a doctor and he wants to prescribe medicine and he just can't because there is no medicine; you cannot find the medicine, that is the most important thing.

I always wish that I could have been in Cuba fifteen years ago to see what it was like, to see how things have changed.

There are problems with the medical equipment now also, but I think that the most important is the shortage of medicines. There are also some subjective problems. There are many people who are in public health; and they are not motivated to work, and they don't work as well as they must.

Why?

Because they, when you work with patients, you need to be human and you know, treat them kindly, be compassionate, many things, be patient. These are all things that a doctor needs to have, and also the nurse needs to have; and most of them now don't have these things, but this is subjective. I talked about this with Elena but I call them subjective problems, problems of people.

Do you mean individuals?

Individuals, yes. Because I have seen them. I have seen the nurses that don't treat patients as they should and as they deserve to be treated well because it is not easy to be ill. You need to be compassionate; and you need to feel, to imagine what they are feeling; and they sometimes are very rude to them. And those are subjective problems that we have because people are not motivated; they have many problems at work and they don't earn enough of a salary. And those material problems affect their relationship with their patients.

So the money is a factor too.

Yes, because everybody has a lack of money. All the salaries are not enough to live on, and this is a general problem. Even doctors, because I have heard them talk about that. And unfortunately that is a bad influence on their behavior when they work and they are not motivated. They have on their mind many things, but you cannot be that way. It is unacceptable in medicine and in public health because the patient needs you first of all, and they deserve the best of us. But I think that when we have enough medicines, when the salaries are higher, and when life is not so difficult as it is now maybe it will help to improve the health care system. Because people in general, not only talking about the health care system, but many people have become not human. I feel that many times when I go out, when I take a bus, when I take a bus with my grandson.

Taking the bus is different from what it used to be like?

Yes, it is very different.

How?

Fidel talked about this once. Well, you know that unavoidable economic problems have their repercussions on personal problems and personal behavior. People outside are angry, they get very angry very easily, they are aggressive, all that because they are frustrated with their situation. If you are at the bus stop for about an hour, an hour and a half, how are you going to be? I don't have

> patience for that. That is why I hitch-hike a lot. I always say that I have patience for everything in life except for the bus. And then when the bus comes, people don't mind if you are old or if you have a child in your arms. They just go to the bus. You know? This is a problem for the last few years, but it will last for more because I think that once this is all over, I think that social problems will be more difficult to solve than the economic problems. I think that with money, with a big change, for example, that we have relations again with the United States, many things can change this economic situation. But the social problems that have been created, this will be very difficult. What we have lost in that sense will be very difficult to regain.

I believe that the above conversation with Selena is an accurate representation of what many Cubans perceive as some of the social problems brought about in the Special Period that in turn affect health. In fact, many Cubans whom I interviewed made very clear connections between the social problems of the Special Period and their effects on both mental and physical states of health. The fact that Fidel Castro has spoken of these problems on Cuban national television indicates that they are common problems faced by Cubans, and that they have reached a point where they can no longer be ignored.

Likewise, many doctors recounted the difficulties of trying to practice medicine in the face of shortages of medications and equipment, and while having to deal with the problems created by poverty. One doctor, when asked how the Special Period has affected his practice of medicine, threw his arms up in the air and exclaimed, "I am supposed to operate tomorrow and I cannot because I do not even have the sutures to sew them back up! Oh, Tracey, you would be here listening to me for years for me to have enough time to tell you all the negative effects of the Special Period!"

As an observer in the clinic, I recall several episodes in which patients would come in to complain that their medication was not available in the pharmacy. This situation would frustrate Anna or whichever other doctor was working, and they would explain to the patients that this was not their fault that they can only prescribe the medications but not guarantee that they will be available. Usually the exchange would end with the doctor prescribing another medication, or replacing the medication with a treatment. One day, after dealing with a patient who was upset about not being able to find her circulation medication, Anna turned to me and said "You see, this is why we have so much stress now; and stress is very bad for health." She then went on to explain that this in turn has increased the number of psychiatric problems, as stress often results in depression and feelings of frustration. One patient exclaimed "There are many stresses now because there is almost nothing to eat, no clothes, we cannot afford entertainment. Do you know that the Habana Libre used to cost eleven pesos a night and the Nacional[114] twenty-one pesos? Now imagine that only *extranjeros* can go there."

Another young doctor, Alfonso, had the following to say:

> We need to get paid more; the government is doing all that it can, but it is still not enough. This is a big problem here because it is difficult to help your patients when you are

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[114] These are the names of two famous (and expensive) hotels in Havana.

> hungry and you are worried about all the problems that you have at home. Not having enough money also puts stress on the family, and we argue more than we normally would. We doctors have the same problems as everyone else. We are all affected, but it is not the government's fault; they want to pay us more but they cannot, and so we must suffer until things get better.

Likewise, in one of the clinics where I spent some time, Arturo, the doctors' favourite technician, quit to pursue a career as a musician. I was surprised because I thought that Arturo really enjoyed his job, since he participated in many volunteer activities, took many extra courses at the clinic, and had even written an information pamphlet on *fangoterapia* in his spare time. On his last day, Arturo told me that he loved working in the clinic, but that he could not afford to stay.

> It sounds strange, I am sure, but I can make more money singing to tourists than I can working in this clinic. And my girlfriend and I want to get married and we want to have a baby, but I cannot afford to feed any babies with my salary.

It was a sad day when Arturo left, not only because everyone was going to miss him, but also because it was a painful reminder of one of the most fundamental contradictions of life in Cuba - that those who spend their lives in the service of the revolution are often those who suffer the most.

Angelina, a patient I interviewed, had some interesting comments about how the Special Period has affected her health.

> It [the Special Period] has definitely affected my health. The transportation is so bad that I cannot move about as I once did; also I cannot use the sauna at the Habana Libre because it is now for tourists only. The sauna is very good for your health, you know? I love the sauna but now... You know the problem with our health care system is not the doctors - they are very good - but the hospitals lack hygiene

> because they don't have cleaning supplies, towels, the liquid for the x- rays; they are missing many things that they need to stay hygienic. Often they don't have water even! Everything costs dollars now too. Every time they build a new store, it is not in pesos but in dollars. All of Cuba is *dolarizando!*

The word *dolarizando*, literally dollarizing, is a verb that was introduced into Cuban popular discourse once Cuban possession of American dollars was legalized in 1993. The *dolarizando* of Cuba has become a major problem that many Cubans are forced to deal with. In fact, many Cubans told me that the legalization of the American dollar has created a new class of people - those who have access to dollars and are much better off financially than those who do not. Another recent introduction to the Cuban vocabulary is 'chopping.' Taken from the English verb shopping, it is used as a noun to name the stores where one can purchase products only in dollars. I went to the largest 'chopping' with my friend Vilma and saw many Cubans hanging around, admiring the many items that most of them will never be able to buy. I asked Vilma,

> *Who buys this stuff?*
>
> Some people have family in other countries; and when they come here, they buy these things for them. My neighbour, she has a sofa from here that her son bought her when he came to visit from Miami.
>
> *Are there other ways a Cuban can own these things?*
>
> Well, yes um... some people work with tourists and sometimes the *extranjeros* give them money or buy them some things; but me, I have no one. I have a son who lives in Colombia; but he has just left, and he has a family and they have no money, but he says maybe he will in the future. I miss him, you know? Just last week I could not get

> up because I was crying the whole day for missing him! Oh, my heart hurts sometimes for that. But yes, some Cubans have better luck than others; but it all depends on who you mix with. It is terrible because you know before, we used to be rewarded for revolutionary activities - for being a good revolutionary. You know, doing voluntary work and things; but now you are rewarded for being a *jinetero*.[115] I think that he [Fidel Castro] had no choice but to let us have dollars, but look at the mess it has made of our country.

Vilma is one of the unfortunate Cubans who do not have direct access to dollars. Many Cubans today have made accessing dollars a central focus of their day-to-day activities. Many doctors and engineers have become taxi drivers or waiters, and there is an increase in the number of *jineteros* and *jineteras* who exploit tourists. Most Cubans recognize a degree of prostitution that has not been seen since prior to the revolution. It is viewed as a huge problem that affects both the morale and the health of those involved. However, foreigners visiting Cuba often misunderstand prostitution in Cuba. A *prostituta* is very different from a *jinetera,* although in the western media the two are often used interchangeably.

> *What is the difference between a jinetera and a prostituta?*
>
> Well... I don't know, I guess because a *jinetera* is someone who, who has more control. She is not so much a victim like a *prostituta*. She is not a good person either; she has sex with men so that they will buy her pretty clothes or a dinner in a nice restaurant, or take her to a disco. A *prostituta* is someone who has sex for money, right?
>
> *Well, in Canada that is what we call a prostitute.*

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[115] The name given to a person who hustles tourists in a variety of different ways.

> Well, here too, but a *jinetera*, that is different. She may just want to be with the man so that she can get things from him. But this is a problem of the times. Before, this was not so much a problem. I think that there are more *jineteras* than *prostitutas* in Cuba.

The word *jinetera* comes from the Spanish word *jinete* that means rider or jockey, and so implies a certain degree of control. In fact, the word *jinetero* or *jinetera* is used often to refer to anyone that people perceive as using a tourist to meet an end of any kind. For example, the two-year-old son of my friend Alina would always greet me with a big hug and kiss, and ask to be held by me. One day as I was holding him and talking with him, his mother joked, saying "Oh, Arielito! You are a *jinetero* for sure!"

HIV and AIDS in Contemporary Cuba

Both *prostitutas* and *jineteros* face very real health risks such as HIV and Hepatitis C[116]. Statistically, the island has one of the lowest rates of HIV infection in the world (Holtz, 1997). According to the Centre for Disease Control, HIV/AIDS Surveillance Report published in February 1990, there was only one baby born with HIV in Cuba compared to one in every 61 births in New York City, reaching as high as one in three in some of the poorer areas of the world (Wald, 1990). Based on a 1997 survey conducted by Holtz, only 609 Cubans had AIDS (five of whom were children), and 1678 are infected with the HIV virus, making the infection rate 0.02%.

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[116] All Cubans are required to be vaccinated against Hepatitis A and B.

However, the low rates of HIV/AIDS in Cuba is a hotly debated issue. The low rate of HIV infection is usually attributed to a national sanatorium program. In Cuba, AIDS is treated as a public health emergency. Cubans who are tested HIV positive are brought to live in a sanitarium where they continue to receive their salary, a well balanced diet, and the best medical attention available. Initially, residing in a sanatorium was not done by choice but required under strict penalties. Many scholars and politicians outside of Cuba saw this as a direct violation of human rights. Leiner (1994:161) is one scholar who openly opposes Cuba's sanatoriums.

> Cuban social policies express views held by particular political and religious groups found in every country...social construction of AIDS and of people who have tested HIV-positive; it is contrary to the spirit of science and enlightened social policy.

In 1990 Karen Wald interviewed several people living in the sanatoriums, and found a wide range of responses to the policy. Some report enjoying life in the sanatorium, and feel more supported and accepted than they do outside, while others only want out. She also reports that patients did not feel that living in the sanatorium was a violation of their rights. However, in 1993, Cuba changed its sanatorium policy and made residence optional, provided that the infected person would agree to behave responsibly in society (i.e., not engage in an activity that would risk infecting others with the virus). Despite this change in policy, over seventy per cent of patients chose to remain in the sanatorium (Holtz, 1997).

However, the sanatoriums present a problem beyond the question of violating individual human rights. Sometimes referred to as the 'Golden Cage' policy, the presence of the sanatoriums provides a false sense of security to the Cuban people. Many people believe that everyone with HIV is safely tucked away in a sanatorium somewhere, and therefore the use of prophylactics is still not seen by many as necessary for protecting one against infection. But many health care professionals whom I spoke with fear that HIV/AIDS is on the rise in Cuba; the main reason given is the spreading of viruses by prostitution and *jineterismo* (see also Barry, 2000). The government of course is aware of this problem, and has begun nation-wide campaigns to promote 'safe sex'; but the use of condoms remains unpopular with many, including tourists. Many people attribute the unpopularity of condoms to *machista* attitudes of some Cuban men; others attribute it to the fact that many Cubans do not perceive HIV/AIDS to be much of a health risk. The majority of the women I spoke with about contraception told me that they used something called a 'T' that acts much like an IUD to prevent pregnancy, but provides no protection from HIV infection.

During a previous visit to Cuba in 1996, I attended a conference in which HIV and AIDS in Cuba was the main topic of conversation. The government has been setting aside a large number of resources to look for a vaccine to protect against HIV, and I was told that they were about to begin their human testing. Scientists and researchers were very careful to point out that they had met all of the international standards set out by the WHO in order to bring them to this stage of research. One researcher joked and said they must be very careful to follow all the rules because the international community has trouble believing that a small 'third-world' country could be so advanced in the area of medical technology. When I returned, I enquired about human testing of the vaccine; and was told that it is in process.

Conclusion

It is obvious that within the current Cuban health care system, there is a set of boundaries in place that are meant to structure the way in which *la medicina tradicional y natural* is practiced. What is not obvious is how and to what extent these boundaries are maintained in actual practice.

It seems obvious to say that doctors and patients are, like anyone anywhere, individuals. However, both the Cuban people[117] and biomedical physicians in general, are two groups of people that are often portrayed as homogeneous blocks, confined by their politics and history or their socialization and education respectively. The Cuban people do have a shared culture in the sense that there are certain unspoken rules that govern what is socially accepted behaviour. This has largely been shaped by Cuba's history, socio-economic condition, geographical location, and political situation. This shared culture acts as an inter-subjective and dynamic backdrop for the individual experiences and interpretations that occur. It seems only logical that a society with a rich medical history, that includes biomedical as well as traditional medical practices, would exhibit a wide range of responses to the new health care policies in Cuba.

Hahn and Gaines (1985) have written an ethnography on American physicians that describes a group of people that, while constrained by biomedical philosophy as dictated by the American Medical Association (AMA), remain a diverse group of individuals who conceptualize and act on these constraints in disparate ways. While both the Cuban and North American medical systems share a primarily biomedical philosophy (Cuba even uses North American medical text books to teach their medical students), this 'biomedical culture' (see DelVecchio-Good, 1995), while maintaining certain key components (e.g., the germ theory of disease), interacts with the local culture, politics, and economics in which it is contextualized; and therefore takes a unique form in practice and experience. The interaction with local cultures and politics further accounts for the fact that the objectives of the institutionalized bodies that govern the practice of biomedicine (i.e., *Ministerio de la Salud Pública*

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[117] See Pastor (1996) for a review of how scholars have generally portrayed Cubans as a homogeneous block.

and the American Medical Association or Canadian Medical Association) differ.

Up until the early nineties, the official Cuban health care system was almost exclusively biomedical. At the official level, most of the new alternatives have been introduced as an economic measure to help salvage what Cuba proudly boasts as one of the best health care systems in the world. In this case, traditional and alternative medical practices serve as filler within a biomedical system. For example, at the clinic where I conducted most of my participant observation, courses in acupuncture were taught not just as a procedure but also alongside the basic Chinese philosophical conceptions of Yin and yang, the balancing of Qi energy, etcetera. However, in actual practice, acupuncture was usually prescribed as a treatment for pain by a doctor who would indicate on a piece of paper the acupuncture points that needed to be penetrated, and a technician would perform the actual procedure. In these cases acupuncture was used as a therapeutic modality within a biomedical system that adheres to a philosophy of allopathic treatment, and was further fragmented by having one person perform the diagnosis and a second person perform the actual procedure.

Likewise, in Anna's *consulta* I saw many patients being treated with homeopathy, using the allopathic conception that X medicine can be taken to cure X illness. However, I also saw Anna use homeopathy according to the homeopathic conception, whereby a homeopathic interview was conducted to determine a patient's constitution; and a medication was then prescribed to help the patient's body strengthen itself, based on this information. Anna saw no reason why homeopathic medications could not be used in both ways; but indicated a preference for the homeopathic use over the allopathic use of homeopathic medications, repeating that she believes the allopathic concept of medicine deals with parts of a person and not the whole, a statement I often heard from doctors who practice various forms of alternative medicine in Cuba.

Pedro's *consulta* was another story. Pedro used acupuncture to treat a variety of illnesses; but emphasized that the point was not to "cure" the patient, but to put the patient back into a state of balance whereby they can learn to "move with the disease" or reach a point where they no longer "need the disease." Pedro claimed this is what his Chinese professors taught him, and that it produces predominantly positive outcomes in his patients. Pedro was not, however, unaffected by the boundaries of official policy. One day as I watched Pedro bleeding the ear of a patient who suffered from chronic asthma, he expressed his frustration that he was not permitted by MINSAP regulations to bleed the patient to the extent that he believed necessary.

All three of the above scenarios imply that at least *officially,* alternative therapies are seen as being primarily a response to the current economic crisis. I even heard many Cubans refer to the use of *la medicina verde* and other alternative therapies as a *vamos a resolver,* meaning literally 'we are going to solve.' This expression is often used in Cuba as a noun to refer to invented objects that solve an immediate problem, or to a number of state-imposed solutions to the economic problems of the Special Period. For example, one day while waiting for a bus, a friend of mine told me that the camel buses are a *vamos a resolver* because they can carry many people at a time and therefore save on gasoline. The repeated reference to alternative therapies as *vamos a resolver* implies that they are perceived by some as being used to remedy a problem in the health care system such as a lack of biomedical drugs. However, as illustrated through the wide divergence of responses from the doctors and patients whom I interviewed, this official view is not directly reflected in the real experiences of doctors and patients.

Good and DelVecchio-Good (1993) state that they are concentrating on the phenomenological dimensions of medical knowledge; on how the medical world, including the objects of the medical gaze, are built up; how the subjects of that gaze (i.e., students and physicians) are reconstituted in the process; and how distinctive forms of reasoning about that world are learned. They argue that biomedicine manifests itself in different forms, depending on the clinic, the practitioner, and the type of medicine studied (Good and DelVecchio-Good, 1993: 81-85). My own research in Cuba has shown this to be the case, not only with biomedicine but with the use of alternative medicines as well. In Cuba all doctors receive the same basic medical training, that consists of six years of post-secondary education. After working as a family doctor for at least two years, most doctors go on to receive specialized training in at least one sub-field of medicine. The specialization in *la medicina tradicional y natural* is a further four years of post-secondary education; a doctor may do a Masters degree in *la medicina tradicional y natural* for two years, or may simply take workshops in various therapies in order to practice certain techniques at a basic level. National and international conferences are seen as another legitimate form of gathering information about alternative medical practices and furthering one's education about such practices. Additionally, many doctors I interviewed spent a great deal of their free time studying and searching out information about alternative medical practices to further their own personal understandings.

Many doctors in Cuba feel that alternative medical practices are not given as much prestige as the more conventional biomedical practices, and many feel limited to some degree in their practicing of alternative therapies. Some even feel resentful of the limitations they believe to be enforced by MINSAP (i.e., Rosanna). However, the majority appear to interpret and utilize MINSAP policies according to their own personal preferences, whether that be not to use them at all (i.e., Hugo), or to replace biomedical practice completely with traditional medical systems to the point where they may even restructure their own personal lives accordingly (i.e., Pedro). Even Blanca, a very well respected doctor who holds a great deal of political power, appears to be broadly interpreting health policy to the point where she practices what she calls *holistic medicine* or *la medicina tradicional china* almost exclusively, within what she believes to be its own philosophical context. One would not expect Blanca, who even acts as a spokesperson for the state in many cases, knowingly to extend the boundaries laid out by the state. Yet the extent to which Blanca embraces these alternatives could be seen as a rejection of biomedical conceptions of illness and disease causation. This would seem to indicate that the boundaries are more flexible than originally believed. How these doctors choose to use or not to use alternative medical therapies affects the nature of the care that their patients receive.

Good and DelVecchio-Good's study further states that "within the life world of medicine, however, the body is newly constituted as a medical body, quite distinct from the bodies with which we interact in everyday life (1993:90)." However, the very structure of the Cuban medical system does not permit the patient to be reconstituted in such a way that they become machine-like replicas of the people with whom the doctors interact on the street. Family doctors are required to live in the neighborhood of the patients for whom they are responsible. Likewise, most of the doctors in the clinics and hospitals live nearby. Doctors are told to keep records of their patients, which include their family situation; and to keep the necessary medications available for patients with special needs in their area (e.g., diabetics). The doctor-patient relationship is very humanistic, and the fact that doctors and patients are often mutually described as *vecinos* (neighbors) and *amigos* (friends) has a direct impact on their interaction in the clinical setting. Furthermore, in Cuba, the doctor-patient relationship is not just between the doctor and the patient; rather, there is a third dimension to the discourse on patient health and well-being - the social dimension. One doctor I knew wrote a letter for one of his patients to her surgeon, explaining that she was very afraid of the surgery, and asking him to treat her as compassionately as possible. Most of the doctor-patient discourse that I observed during my time in Cuba included at least a brief discussion of the patient's family and/or social situation, and this was taken by the doctor as a factor in the diagnosis and treatment of the patient.

Furthermore, Good and DelVecchio-Good's study (1993) of the socialization process of American medical students found that

> American medical culture is characterized by an ideology that reifies the domains of 'scientific facts' and 'human values' through the juxtaposition of two key symbols, 'competence' and 'caring'; and that the training of students to be 'competent' physicians entails a reconstruction of commonsense views of the patient, sickness, and the personal boundaries of the medical student. Students experience a culturally distinctive configuration of contradictions as they attempt to maintain qualities of 'caring' while encountering the world of medical science (Good and DelVecchio-Good, 1993: 91).

The value placed on competence over caring within the institution of American medical schools creates a situation in which North American doctors are conditioned to conceptualize the two as independent of each other. This does not appear to be the case in Cuba. I lived in a home with two doctors, both specialists. Several times a week, patients would stop by the house to look for advice on their various medical problems. These patients were always welcomed and treated as any friend would be treated. Furthermore, patients called frequently; or would stop the doctors on the street to discuss their treatment and progress, or just to chat. Likewise, I spent many weekends in the home of Anna, where patients would frequently call or show up to see her. She even invited the occasional patient to her home to pick up a remedy that had been donated[118] to her that she thought might help them. One day at the clinic where I conducted the majority of my participant observation, I was discussing the problems and issues of mind-body dualism in medical science with one of the allopathic doctors who works there. He turned to me and said *Tracey, es porque no puede ayudar friamente*; literally, "Tracey, it is because one can not help coldly." I had heard this statement before, and believe it nicely illustrates the approach to healing that I found to be characteristic within the clinic where I did my participant observation. The general consensus was that in order to be a competent doctor, one must also care for patients on a professional as well as a personal level. While the doctor-patient encounter in Cuba is most definitely influenced by biomedical concepts of disease and disease causation, there remains a deeply social aspect to the relationship. Doctors are encouraged in school to know the patients for whom they are responsible. A family doctor, who serves as the first line of treatment, must live among his or her patients as a neighbour and as a friend. Not interacting with those around you would be considered a very antisocial activity which would likely lead to social rejection.

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[118] When attending conferences, many doctors from other countries make donations of various medications. Usually these donations are made to the pharmacies; but sometimes they are given to the doctors themselves, who in turn pass them on to their patients.

In some cases doctors would help family members by not revealing a patient's complete medical situation to the patient. For example, one day when Benny was not present, Lazaro (his doctor) and Ina (his granddaughter) told me that Benny has colon cancer but that he is unaware of his condition. I questioned them on this, as it seemed strange to me that someone could have such a serious illness and not know about it. They told me that if he knew, he would not try to get better. What was worse, he would make life for Ina very difficult. Ina assured me that it was best that he not know because having *la mente positiva* was also good medicine for Benny. I later learned that Benny had undergone surgery several years ago, involving a colostomy. I again questioned Lazaro and Ina as to how it was possible that Benny could not know that he had colon cancer if he had undergone such a serious operation for it. Ina told me that she told him that the colostomy was only temporary; and that occasionally he asks her when they will reverse it, to which she just responds 'soon.' I asked them if this behaviour was common; and Lazaro told me that most patients know if they have cancer, but in this case, it was better for both Benny and Ina that Benny not know.

The above scenario is an example of how doctors and families in Cuba make individual decisions based on what they believe to be in the best interests not only for the patient but for his or her family as well. It is generally believed that the patient's right to know does not surpass the negative effect that this will have on his or her health, and the ability of his or her family members to care for him or her.

Most doctors who practice some form of alternative medicine, whether to fill a void in the biomedical paradigm within which they operate or to replace the biomedical system within which they were trained, recognize and admit that traditional medical systems are more holistic than the conventional biomedical therapies. Such notions of 'holistic medicine' which are variously described as "treating the patient as a whole person" and "not just treating the illness but looking at all the causes and effects of the illness experience of the patient" are compatible with Cuba's 'medicine in the community' model (described in Chapter one), whereby the family doctor is an active participant in his or her patients' social, community, and sometimes personal lives.

The patients whom I interviewed exhibited a wide range of responses to the introduction of alternative therapies. All patients interviewed reported that they had good relationships with their doctors; and many trusted the opinion of their doctors, and accepted whatever form of treatment they provided. Of course there were patients who preferred allopathic treatments and those who preferred alternative treatments. The reasons cited for preferring alternatives were usually that there are no associated side effects, and because it was *más natural*. However, the vast majority of the patients interviewed saw no conflict between the use of allopathic and alternative therapies; and did not perceive the various systems to be in conflict with each other, so they would generally agree to use whichever treatment their doctor believed to be the most effective. Many patients, when asked which method of treatment they preferred, would say *lo que sirve* (that which works).

Nonetheless, there appears to be a great deal of effort on the part of both the state and doctors to educate and encourage the participation of the Cuban population in their health care. In fact, the participation of the majority of Cuban patients in their health care can best be categorized as active rather than passive. The general public is encouraged to learn about the alternative therapies available to them through television and radio programs, displays in clinics and pharmacies, courses offered through local clinics free of charge, and through various pamphlets distributed when there are resources for printing them. While I was conducting my fieldwork, I went into several pharmacies that had displays of various herbal remedies and what they are good for (see Plate I for an example). At one clinic there was a detailed description of twenty-five different plants, what they can be used for, how to prepare them, and even how one can best grow them. Likewise, I was given a pamphlet titled *Plantas Medicinales y Tóxicas que la Población Debe Conocer* (Medicinal and

Poisonous Plants that the Population Should Know) published by the *Consejo de Defensa La Habana Vieja* that describes (using their common rather than scientific names) some of the more common types of medicinal plants used in Cuba and how to prepare them for use at home. I even came across one small book entitled *El Folclor Médico de Cuba,* documenting treatment narratives from rural persons, with their age and place of residence listed. These narratives were classified according to illness. For example, one treatment given for the mumps by a *campesina* in Camagüey suggested putting a necklace of figs around one's neck.[119]

While it became obvious during my research that some doctors and patients accept the available alternatives as substitutes to fill an economically deprived system, for many doctors and patients (but especially politicians), the introduction of alternative medical therapies is a part of a much larger international trend. The health care reforms are not only meeting an immediate need but also keeping Cuba's health care system, ironically enough, 'modern.' For fewer others, the alternatives introduced are recognized as medical systems in themselves; and thus deserve the respect of being practiced as such. However, the fact that many Cubans prefer to use more than just the *materia medica* of an alternative medical system does not change the fact that they operate within a larger framework that has been created and maintained by a biomedical legacy whose boundaries are not always clear. Therefore individuals stretch and redefine them according to their own perceptions of where the limitations lie. Nonetheless it is a legacy that for many continues to constrain practice.

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[119] *El remedio que conozco para la papera es ponerse al cuello un collar de higuereta.*

In Chapter six I look outside the clinic and the institutionalization of health care into the 'unofficial' sector, which continues to provide many healing traditions that existed before and during the Cuban revolutionary era. Despite the incorporation of *la medicina tradicional y natural*, Cuba maintains several rich and diverse medical traditions that are practiced outside of the official system. In the unofficial sector there are patients who seek medical attention in a world far different from that of the clinic, one influenced more by religion than science. The practitioners here are not doctors but are variously called *Curanderos, Espiritualistas, Yerberas*, *Santeros,* and *Palmonte.*

Chapter 6: Treatment Seeking Behaviours Outside the "Official" System

In this chapter the unofficial health care sector is described; and the reasons for its persistence and increased popularity, in spite of the fact that much of its *materia medica* has been incorporated into the official health care system is examined. This issue is contextualized within larger beliefs and experiences within the everyday lives of Cubans living in a changing Cuba.

Investigating the "Unofficial" Health Care Sector

Most of the research conducted for this chapter was done with the help of a Cuban friend, Dr. Valdes. Dr. Valdes is a vibrant sixty-eight year old man who has lived most of his life in Alonjas. He is a retired medical doctor and military officer who travelled to Angola, where he aided military troops through his medical expertise. Today he lives in a small one bedroom apartment with his mother and his wife Anita; and spends his days providing advice to patients who continue to visit him in his home, caring for his elderly mother, and conducting his own research on various topics of interest to him, mainly alternative medical systems. Dr. Valdes very much believes in the efficacy of most alternative and traditional medical systems, although he is very cynical about the use of alternative medicines in the official system.

When I first met Dr. Valdes, I told him of my research project; and that I hoped to learn more about unofficial and traditional medical practices in Cuba, particularly the religious healing ceremonies of Santeria and Palmonte. I explained that I wanted to learn about individual experiences with the unofficial health care sector, and not just how it is 'supposed to work.' I explained that I wanted to go beyond a superficial study of alternative medical practices as folkloric and reminiscent of days past. He was eager to help me, and we quickly devised a plan to gather information.

Dr. Valdes emphasized that the starting point in any study on Cuban psychology should be to understand the history of the Cuban people, particularly the cultural influences that have evolved and changed through socio-political and economic conditions. Only then, he explained, would I come to a good understanding of Cuban treatment-seeking behaviours and explanatory models of illness. This has been attempted in chapter one.

Definitions

Dr. Valdes and I agreed that after the multiple origins and historical influences on the Cuban people had been presented[120], the next step would be to make clear the definitions to be used. I recorded the following conversation between the two of us shortly after our initial meeting:

Tracey:
Is there 'actual' traditional medicine in Cuba?

Dr. Valdes:
Now there is a mixture.

Tracey:
Is there popular medicine in Cuba?

Dr. Valdes:
No, there are popular therapies. A therapy is the utilization of a method within medicine, but medicine is the art of curing. It is complete; it includes prevention, diagnosing, therapies, and rehabilitation. In Cuba there are therapies for curing or 'popular health,' which refers to knowledge.

Tracey:
What then is traditional medicine?

Dr. Valdes:
Traditional medicine is everywhere. It is in your home, in everyone's home. For example, when you were young and you got a mosquito bite, what did your mom do?

Tracey:
Me? Nothing.

Dr: Valdes:
This is traditional medicine. That is the tradition of your family, no matter what it is. It depends on the group and their ethnicity. For example, acupuncture is a form of traditional Asian medicine. You should get rid of the word medicine and use therapeutic.[121]

Tracey:
What then is medicine?

Dr. Valdes:
Medicine is the art of curing – the art of health (this is what the word means in etymology). I am a *médico* – this is different than a doctor; the art is different than science. A *médico* is an artist and not a scientist. Art is personal, subjective, and individual. Even twins are different. Philosophy

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[120] See Chapter one.

[121] According to the WHO, the term traditional medicine: "refers to ways of protecting and restoring health that existed before the arrival of modern medicine. As the term implies, these approaches to health belong to the traditions of each country, and have been handed down from generation to generation. Traditional systems in general have had to meet the needs of the local communities for many centuries" (WHO, 1996).

cannot give a concept of medicine. What is medicine? There is no philosophical concept. Illness is a very difficult term to describe – philosophically they are just ideas, they are not concepts. To be human is to be ill. The occidental have a concept of health. It is an established mentality. They always see everything in parts or as better or worse. This is their criterion for the health of man. It is statistical – it is not real because we are all different; and so if medicine is an art, then we need to know the sick individually and the relations it has. Allopathy gets rid of signs and symptoms but does not cure, whereas homeopathy does not try to get rid of the fever but to know what causes it. 'A' removes, it means without. What is a healthy man? They always give us statistical information that tells us nothing about the individual and quality of that person's health.

Tracey:
What then is natural medicine?

Dr. Valdes:
There is no such thing as natural medicine because all medicines are natural. Herbal medicines *are fitoterapia; medicine verde* is a common term the people use.

In Cuba, the word *curandero* is a generic term used to refer to any number of individuals who practice some form of healing technique outside of the official sector. They include practitioners of various religious sects (primarily practitioners of Palomonte, Santeria, and Espiritualismo), *yerberas* who sell herbs and provide advice on the use of certain herbal remedies known popularly as *medicina verde*, and persons who are referred to only as *curanderos* or are simply known for their ability to cure common ailments; namely, *empacho*.[122]

The Questions

The next day Dr. Valdes greeted me with a kiss on the cheek and the following statement: "Tracey, now we are going to research psychologically why the people visit or search for those who know of these popular therapies for curing." And then the two of us sat down over a small cup of strong Cuban coffee, and decided on a rough set of questions for the semi-structured interviews we planned to conduct with random persons on the street and in the nearby clinics. When we were finished, our questionnaire looked like this:

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[122] Later, I showed the transcript of my conversation to Anna and asked her what she thought of it. She said that she agreed with Dr. Valdes, and that he had explained this quite nicely.

1. What do you do when you are sick?
2. And after? If that does not work? Why?
3. Is there anything you do in your home to protect your health or that of your family?
4. What does a *curandero/santero* do? (Diagnose, prescribe, advise, etc...)
5. What do they do that is different from a doctor?
6. Where or how did you learn about *curanderos*?
7. Where do you think that traditional or popular medicines/therapies originated?
8. Do you prefer one form of therapy over the others? Why?

It is important to point out that the above questions served as a rough guide. Not all questions were asked of every person, and sometimes other questions were asked.

We then set out to spend twelve days, over a period of three and a half weeks, of interviewing sixty-one people we simply happened upon on the streets and in nearby clinics. Throughout our interviews and discussions, certain trends and beliefs became increasingly apparent. These trends are:

1. Older people are more likely to visit *curanderos*.
2. People from *el campo* are more likely to frequent the services in the unofficial sector.
3. Medical treatment begins in the home.

4. Beliefs about where the knowledge of traditional medicine originates differs from the official reasons presented.
5. There is a perception that those of African ancestry are more likely to use the services provided in the unofficial sector.
6. There is a medical ambivalence among the majority of Cubans.
7. There is a belief that the services available in the unofficial sector are better for treating certain kinds of illnesses.

I will now turn to a discussion of each of these trends and beliefs.

Age

Older persons seemed to have more faith in practitioners outside of the official health care system. On the second day of our interviewing, Dr. Valdes and I came across a group of four men on the street. Dr. Valdes and I approached them and explained that we were collecting data on treatment-seeking behaviours in Cuba. They nodded their heads and waited for our questions. When asked what they do when they become ill, the first three men, who ranged in age from 48 to 62, replied that they visit a *curandero*; and if he or she cannot resolve their problem, they will go to their doctor. The fourth man, who was much younger at 23, said that he goes to his family doctor and if he does not become better, his mother insists that he visit the *curandero*. Once we were finished interviewing these men, Dr. Valdes pulled me aside and asked me if I noticed that the youngest man was the only one who said that the first thing he did was to visit his family doctor. Dr. Valdes explained that older people have a lot more faith in the abilities of *curanderos* because they have had more exposure to them. Members of the younger generation, he explained, were brought up to believe that biomedicine is a superior form of medical practice; so their faith in the unofficial sector is much less.

This, of course, is only one example. However, as our interviews progressed, this trend became increasingly apparent. The persons we interviewed (which included persons on the street, doctors, nurses, and patients) were divided into two age categories: those under 45 and those over 45. In most cases we asked individuals for their age; however, when it was obvious which category they fell into, we did not. Of the sixty-one respondents, thirty-eight were over forty-five; and the remaining twenty-three were under forty-five. Of the twenty-three younger people, only four stated they would visit a *curandero* prior to visiting a doctor, whereas twenty of the thirty-eight people in the over forty-five group said they would first visit a *curandero.*

Rural Versus Urban Origins

While Dr. Valdes and I did not ask all respondents whether they were born and/or raised in *el campo* or in the city, many volunteered this information; or it came out in the course of the conversation. Nonetheless, many persons indicated that there are more *curanderos* in the rural areas of Cuba than one can find in the city. When asked why they thought this was so, the usual answer was that many of the herbal traditions of Cuba originated in the rural areas; because, prior to the revolution, there were few medical doctors stationed in rural areas and furthermore, even when present, a large number of rural peasants could not afford these services.

As a result, a number of healing traditions flourished throughout the countryside in pre-revolutionary Cuba. Today they continue to serve their intended purpose.

One typical response came from a nurse who responded that while she does not visit *curanderos*, she knows that this knowledge comes from *nuestros antepasados en el campo* (our ancestors in the countryside); and that her grandmothers used to treat her with oregano and *tilo* (Linden flowers). She makes these infusions for her own daughter today.

Medical Treatment Begins in the Home

On day six of our interviewing, I approached Dr. Valdes with the following revelation: Have you noticed that when we ask people if when they are ill they see a curandero or a doctor first, they answer either doctor or *curandero*; but when we ask people what do they do first when they become ill, they often say drink this tea or that tea, or they dress warmly and stay inside; and then if still ill, they go to a doctor or a *curandero*? Dr. Valdes responded with an "Of course! In Cuba all medical treatment begins in the home."

In fact, many women responded that when family members, especially children, became sick, they would first make them a tea; or in the case of *empacho*, massage their stomach with oil. One woman had the following to say:

> I do not always trust the doctor's advice. I think that sometimes taking a lot of drugs can be bad for the health of my children. You know, I read that too many antibiotics can cause deafness. I use my mother's intuition when it

> comes to my children and so I do not always get the prescriptions from the doctor. Sometimes I just keep them warm, give them a lot of love, and I make them tea.

Another woman told me that when someone in her family becomes ill with diarrhea, she makes them a drink that contains a lot of salt; and places a burning cigarette in their navel that provides heat that relieves some of the cramping.

Origins of Alternative Medical Knowledge

Recall in Chapters 4 and 5 that MINSAP officials and many doctors maintain that the knowledge for alternative medical practices used in the official health care system comes largely from external sources. Herbal remedies are scientifically studied, Chinese and Korean doctors came to teach acupuncture and other techniques to Cuban doctors, and international congresses are held to share and compare the various methods and uses of homeopathy and Bach Flower remedies. When Dr. Valdes and I asked where the knowledge maintained by *curanderos* originated, the responses were much different.

When asked where does the knowledge for alternative or traditional healing therapeutics come from, the most common answer was "from our grandparents" or "from old people growing plants on their balconies." Dr. Valdes explained that these are popular remedies. For example, *tilo* (Linden flowers) is taken to calm the nerves. This is not *fitoterapia*, he explains. *Fitoterapia* is a therapy for which there is scientific proof that the plant in question has the specific properties necessary to cure a certain ailment; but *tilo* is a popular remedy because, while it is not scientifically proven, everyone trusts from their experience that it will serve the purpose. The method by which *fitoterapia* and *la medicina verde* are displayed and advertised differs in a way that portrays their different philosophical basis. Plate I shows a display of *fitoterapia* in a state-run pharmacy. The display emphasizes the scientific validity of the medicines. Plate II shows a display of *medicina verde* inside the shop of a *yerbera*. The plants in this display are in their natural form, and mixed with magico-religious paraphernalia.

One patient who sat waiting his turn in the *cola* to see the doctor explained to me that acupuncture and moxibustion were brought to Cuba hundreds of years ago by the first Chinese-Cubans, a theory that was repeatedly refuted by government officials:

> In Cuba some people came from China a long time ago, right; and among them some of them brought this science from their ancestors, and they began to develop it here in small clans in the Chinatowns. Some of them taught Cubans. I think this is because they thought, OK, the boy is prepared, so I am going to teach him so he can help his clan, or whatever because it is the system. They brought also Kung Fu, they brought also Tai Chi, they brought moxibustion, they brought many different things. It is a system of which acupuncture, for example, is just a part, Qi Gong is just a part, massage is just a part; but when you are taught a system you begin to learn bit by bit the different things about this system. So it is quite possible that many people learn from these sorts of people, and not just because they were doctors or they had the support of any institution. You can go there and you can see this but you have to find them first, and that is the hard part.

Plate I: *Fitoterapia* Display in a State-run Pharmacy

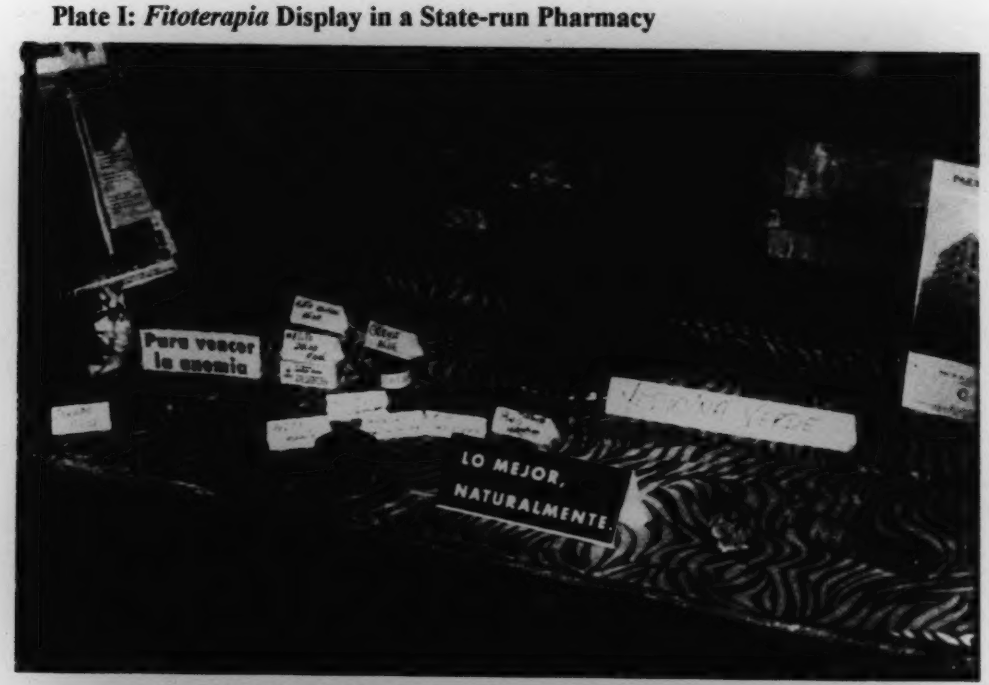

Plate II: *Medicina Verde* Display in a *Yerbera's* Shop

The patient next to him then stated that *la medicina tradicional* is not new to him. He has been taking honey and garlic since he was a child to treat the cold. "Now that there are economic problems, the government is using this knowledge too."

African-Cubans and Curanderos

Repeatedly throughout our interviews I heard references made to the idea that *mulattos* and African-Cubans are more likely to visit practitioners outside of the official health care system. Although this tendency did not appear to be present to any recognizable degree within my data, Dr. Valdes also believes this to be the case. For example, when a younger respondent related that she always went to the *curandero* before seeing her family doctor, Dr. Valdes said that the reason she answered this way is because she is a *mulatto*. When I pointed out that numerous Spanish-Cubans stated the same thing. Dr. Valdes told me that *curanderos* are a Cuban reality and so all Cubans from every group will go to them; but really it is something that is more common for the *mulattos* and the African-Cubans. When I asked why he believed this to be so, he said that it is an African religious phenomenon.

Later we met an older woman standing in the line at the *bodeca* with her two-year-old granddaughter, waiting to pick up her rations. After proudly proclaiming that she is a second generation Spanish-Cuban, she proceeded to describe the numerous herbal remedies that she makes to treat herself and her family. She grows *manzanilla* (chamomile), *yerba* *buena* (spearmint), and oregano on her balcony; and she treats her arthritis with *ajo* (garlic) and her high blood pressure with *cebolla* (onion). The plants, she tells me, can do the same thing as pills and without the side effects. I asked the woman, at Dr. Valdes' prompting, if she thought that African-Cubans were more likely to visit a *curandero* than was a non-African-Cuban; and to Dr. Valdes' surprise, she said she did not think that it mattered. Afterwards, she showed me her granddaughter's stomach. The two-year-old's stomach had some sort of plant taped into her navel. The woman told me that she had put it there to cure the young girl's hernia. This, she explained, "works best for white people."

One day after we were tired of walking around, Dr. Valdes and I sat down for one of my 'lessons'. In this lesson Dr. Valdes explained to me, as he repeatedly had before, that the Cubans are a '*mescla*' or a 'cocktail.' He maintained that Cubans are not Latinos but a mixture of Latin, Spanish, Chinese, and African. This mixture has, of course, influenced the form and shape of medical practices on the island. Dr. Valdes further explained that the Indians of Cuba had medical knowledge; but the Spanish introduced diseases, from which the majority of the Indians died. However, they had passed on some of their medical knowledge to the African slaves. The African slaves had some knowledge of their own; but since the flora and fauna of Cuba differed greatly from that of Nigeria, the Congo, and Sierra Leone, their practices changed somewhat, and therefore so did their knowledge. As such, the origin of a number of today's healing practices in the unofficial sector is Africa. But since Cubans are such a mix, nearly every Cuban has some African background. Even the Cubans who maintain that they are only 'white' or of Spanish or French descent, Dr. Valdes explained, are heavily influenced by practices that originated in African culture. He gave me an example of a wealthy Spanish family before the revolution whose children were raised by an African-Cuban nanny. These children, he concluded, may not have African blood; but they do have African culture. They are a mix; all Cubans are a mix, and everything here in Cuba comes from that.

Medical Ambivalence

According to Dr. Valdes, this Cuban 'mix' that he spoke so much about further explains why the majority of Cubans do not see a contradiction in using multiple forms of therapeutics within the same illness episode.

Our first stop on our first day was to Dr. Valdes' own *médico de la familia*. Dr. Sanchez is a young woman who has already completed her specialization in traditional medicine, but still practices in the family clinic every morning. Dr. Sanchez says that traditional medicine descends from *nuestros abuelos* (our grandparents), but that it has been scientifically 'refined' for practice in the clinics. She gave us the same story as the majority of the doctors whom I interviewed, and whose data are presented in Chapter 4. She said that acupuncture, as well as many other alternative therapies, were taught by visiting Chinese doctors. We asked her if she thought any of the traditional Chinese medical knowledge came from the Chinese Cubans. She told us that while in *Barrio China* (Chinatown) there were some traditional Chinese acupuncturists who brought this practice to Cuba hundreds of years ago, they would have been the rare exception, since the majority of the Chinese who came to Cuba were poor labourers. Dr. Sanchez told us that her patients come to her with a lot of questions about the alternative therapies she offers (mainly acupuncture, massage, and herbal prescriptions). Her patients come to her with their health problems first; and if she is unable to help them, they will visit a *curandero*. I asked her if she felt that the *curanderos* posed any sort of threat to the patronage of her practice, and she replied that this did not in any way threaten her practice.

> No, no! Why? Sometimes patients have problems that I cannot deal with, and so they must see a *curandero* or a Santero or a priest of some kind. If I cannot help them, I want them to be able to get help somewhere else.

In Dr. Sanchez' clinic, Dr. Valdes and I spoke with four of her patients who were patiently waiting their turn in the *cola*. Three of the patients eagerly told us stories of how they would go to see a *curandero* for certain problems such as *empacho*, love sickness, or illnesses caused by *mal de ojo* (evil eye); but for other illnesses, they would see their family doctor, or go to a hospital. The fourth patient told us that he always went to his family doctor, and felt no need to pay a *curandero* for what a doctor could better treat.

In another nearby clinic, Dr. Gomez sees patients every Monday to Friday from 9 a.m. to 12 p.m. Dr. Gomez told me he treats nearly all of his patients with homeopathy and acupuncture. I asked him how his patients learned about homeopathy, since it was still a relatively new practice in Cuba.

> The Cuban patient has a great deal of knowledge about health. All Cubans know about health, but not many Cubans know about homeopathy because it is something new. But I explain it to them and they are interested and want to learn about it; and when they know what it is, they usually like it. The Cuban patient is very open, very receptive; and generally always when he hears or sees that other family members or a friend has improved with something, well, then, all of them go for it.

Another doctor told me that some of his patients frequent *curanderos*. He has no problem with this, and does not see how it would present a conflict with his own practice. He told me that the main thing is to *resuelve la problema* (solve the problem). The nurse at this same clinic told me that she has gone to a *curandero;* and that many of her patients do, as well. When I asked her why she thought people see *curanderos* when doctors are so easily accessible, she replied that going to a *curandero* can't hurt, so why not?

It appears as though the Cuban population has access to a wide range of advice on medical issues; and, in general, there is no perceived conflict between utilizing more than one set of recommendations for treatment. "If the doctor cannot help me, I see the *curandero*" or "If the *curandero* cannot help me, I see the doctor" were common statements coming from patients in the clinics and people on the streets. Even the doctors themselves expressed little concern for their patients' ambivalence or lack of adherence to one medical system. Most patients and some doctors even recognized that *curanderos* might be better able to treat certain types of illnesses.

Many examples of this sort of ambivalence can be found within the anthropological literature. For example, Whiteford (1999) found that throughout Latin America, particularly in rural areas, no single medical worldview has been regarded as superior to others in all circumstances. Likewise, James Waldram (1990) in his study of Canadian aboriginal persons in Winnipeg, Manitoba, found that in general the people in his study see no conflict in using both traditional and biomedical systems of medicine, regardless of the strained relationship between the two systems.

Later, in another lesson with Dr. Valdes, he went through what he states are the three reasons that account for much of the ambivalence in Cuban treatment-seeking behaviours.

1. *Motivos psicológicos* (psychological motives): for any illness episode, one of the most important factors affecting treatment-seeking behaviour is faith. If you do not have faith in the scientific methods of biomedicine, it will work against you and possibly even cause the condition to deteriorate further; whereas if you do have faith, it will work for you. Dr. Valdes explained that most illnesses will get better even if the

patient does nothing. So it is faith, or lack thereof, that either motivates the individual to heal, remain ill, or become even more ill.

In one case in the clinic where I conducted the majority of my fieldwork, a patient was told that the best method of treatment for her arthritis was acupuncture. Upon hearing this, the patient suddenly became very uneasy; and asked Anna for another form of treatment. Anna explained that acupuncture was the best treatment for her particular condition but the patient continued to resist, claiming that she was afraid of the needles. Finally Anna conceded and prescribed several sessions of laser-acupuncture instead. Satisfied with this, the patient left to receive her first treatment. Afterwards Anna told me that the acupuncture would only have caused more harm than good because the patient was so afraid of it.

For Dr. Valdes and to some extent for Anna, with most illness episodes, the type of treatment is not important. In most cases, the most important predictive factor in any treatment is the psychological state of the patient, the patient's *fe* (faith) in the treatment. There is much evidence in the psychoneuroimmunology literature that suggests that under certain conditions and for many illnesses a placebo can be just as effective as any other form of medication (see Weil,1988). Likewise, a patient's trust in his or her physician may serve as a placebo-like therapeutic mechanism (Shorter, 1985).

2. *Motivos culturales* (cultural motives): Dr. Valdes returned to his assertion that the Cuban people are *una mescla*. Cuban cultural influences

are diverse. Medical books are largely North American, so the official practice of medicine has been influenced by the culture of biomedicine present in North American medical practices (Good and DelVecchio-Good, 1995). At the same time Cuba has a rich herbal tradition that flourished in the households of the poorer rural people prior to the revolution, when health care was not accessible to a large portion of the population. Likewise, the strong religious influences of African-based religions carried healing traditions of their own, with ceremonies recognized as effective for a variety of illnesses. Given the plethora of accessible treatment options available in Cuba today, the choice of whom to consult for medical advice depends on individual beliefs, the experiences of individuals with the various forms of treatments, and the nature and type of the illness episode.

In the end, according to Dr. Valdes and according to my research findings, if an individual has faith in biomedical science, he or she will consult a doctor; if they have more faith in the abilities of a *curandero* or a religious healer, they will consult such individual first. ***First,*** because most Cubans consult both. In reality, for many Cubans the first treatment is in the home.

Upon presenting these findings to a medical professor whom I had interviewed, he responded:

> Yes, I would say this is true. Cubans are ambivalent toward their treatment. They have *ambivalencia psicologica afectivamente* in the way they search for health. All of Cuba is a mixture, and all the forms of treatment are too. If

> there are no medications or if a doctor or a *curandero* cannot solve the problem quickly, then they will go somewhere else. It does not matter to many people.

3. *La motividad que proposiciona a los symptomos* (What motivates the symptoms): Different illness episodes have different causes. Often a doctor can cure the symptoms but cannot change what has caused the illness. Sometimes a patient must seek out the services of a practitioner in the unofficial sector to 'break' the 'tie' that has been made between himself or herself and another person (as in the case of love magic), or to break a curse that has been sent by another (as in 'evil eye'). Sometimes alternative practitioners are simply better at healing certain physical manifestations of pain and discomfort (as in *empacho*). This brings me to the next factor.

Depends on the Illness

> I almost always go to the *curandero* instead of the doctor.
> *Why?*
> Because they can better help what it is wrong with me.
> *What do they do that is better to help with what is wrong with you?*
> Well, you see, most of my illnesses are caused from love sickness.

The above is a typical explanation for searching out the services of a practitioner in the unofficial sector. Among users of multiple systems of healing, there is a general consensus that *curanderos* and religious practitioners are better equipped to deal with certain illnesses, namely *empacho*, love sickness, and *mal de ojo.* According to Finkler's (1991) comparison between biomedical workers and practitioners of *espirtualismo* in Mexico, when biomedical treatment fails, patients often assume that the ailment was caused by witchcraft.

Empacho has been similarly defined among most Latino groups as

> a condition wherein food or other matter gets 'stuck' to the walls of the stomach or intestines, causing an obstruction. It is thought to be caused by dietary indiscretion - often by eating too much food or spoiled food, inappropriate combinations of food, or eating at the wrong time. In children, *empacho* can also occur if a child swallows too much saliva during teething, or when a parent changes types of infant formula, or changes over from infant formula to milk (the thought being that the different formulas of milk will mix and cause a *pelota*, or ball of material that will stick to the stomach). (Pachter, 1994:691; see also Weller et al., 1991 for a study of *empacho* in Guatemala).

Symptoms of *empacho* include nausea, stomach cramps, stomach ache, lack of appetite, and a bloated stomach. Treatments usually include dietary restrictions, herbal teas, and abdominal massage.

According to a study done by Pachter et al. (1992), only 9% of the 67 Puerto Rican parents he interviewed in a hospital waiting room of a pediatric clinic in Hartford, Connecticut, found that *empacho* could be cured by a physician. Physicians were therefore not found to be very effective at dealing with *empacho*. Many parents took their children to a physician anyway because this was seen as part of the diagnosis, but the illness was generally perceived as being outside the domain of biomedical treatment. In this study, parents would seek out advice and treatment at home, from a *curandero*, or a physician; and alternate between them.

In my own research I found similar tendencies. A patient named Sara explained that during one illness episode she was sure that she had *empacho,* and felt that a *curandero* was better suited to treat this illness. She told us that upon visiting the *curandero*, the *curandero* asked her to lie on her back while she rubbed an oil into her stomach. The *curandero* explained that an obstruction was causing her pain, and massaged the oil in a circular motion over her stomach until she found a *pelota*. Once the *pelota* was located, the *curandero* pushed downward for several minutes; and gave the patient a drink of herbal tea. The patient was later able to pass the *pelota,* thus relieving her pain. She later volunteered to take us to the *curandero* who was known in her neighbourhood for being particularly successful with treating *empacho.*

When we arrived at the home of the *curandero,* we were welcomed by Isabelita, a friendly middle-aged woman who quickly sat us down and offered us a *cafecita* and some small shortbread cookies. She then showed us pictures and told us stories about her two sons and their families as though we were old friends becoming reacquainted. After what must have been an hour, Sara explained to Isabelita that we were interested in learning about *empacho*. She smiled and asked me to lay down, and assured me that she would alleviate my discomfort within half an hour. Just then a man entered from an adjoining room and began to explain to me that Isabelita is a gifted *curandero,* and that I would be feeling better in no time. I quickly explained that I did not have *empacho* but that I was studying the various treatment options available to Cubans who become ill. She laughed and explained that she was embarrassed because she had thought that I was there for treatment. She then began to ask me a number of questions about my study. Once I had satisfied her curiosity, I began to ask her some questions of my own.

What is *empacho*? I asked her. She explained that it was like what the doctors call indigestion but it has other symptoms such as constipation, cramps, and a lump in the abdomen that sometimes results in severe abdominal pain. Before I could ask her about the cause, she told me that people with *empacho* have usually eaten too much, or something that does not agree with them or something that is too heavy. She emphasized that pork and cheese are common culprits in causing *empacho*. This food then forms a *pelota* in the individual's stomach or intestine that gets stuck and cannot easily pass.

"Do you have a cure for *empacho*?" I asked.

"Yes, of course," she responded "that is why people come to see me, I am very good at curing *empacho*; even doctors," she explains, "send their patients here."

Isabelita brought me into her kitchen and showed me her *yerba buena* and oregano plants that she mixes with cooking oil and then heats on her stove to form a massage oil. She then rubs the oil softly over the patient's stomach until she feels a bump that she identifies as the *pelota*. She then massages the *pelota* with strong downward strokes for twenty minutes or so or until the *pelota* begins to move and the patient begins to feel better. Usually, she explains, the patient will then be able to pass the *pelota* in a bowel movement; but if not, she will rub their back in a specific fashion, which she then demonstrated to me on the man who was in her apartment. As she pulled up handfuls of skin away from his back, she explained to me that she learned this practice from her grandmother; and that I should learn this for when I have children of my own, since they are especially susceptible to *empacho.*

Most of Isabelita's patients are unable to pay for her services with money. Most bring her gifts of food, cooking oil, and toiletries; but some bring her nothing at all. She says that she does not mind because she understands that times are hard in *el periodo especial,* and her services are free of charge. People only pay if they wish or if they are able.

Empacho has been variously defined within the literature as a 'folk illness' that is defined by Pachter (1994:691) as "illnesses that are commonly recognized within a cultural group, and whose explanatory models often conflict with that of the biomedical paradigm." While I have emphasized that in general, Cuban physicians are not opposed to the idea of visiting a *curandero* to cure such illnesses as *empacho;* and that in fact many Cubans, including doctors, see the *curandero* and their services, which are external to the official system, as being better equipped to deal with such illnesses. This is not always the case, however. Biomedical indoctrination in Cuba, while not as strong or rigorous as in other nations where its practice predominates, is still present; and there are still individuals who adhere to its superior ability to cure any illness despite the many voices to the contrary.

For example, following my visit with Isabelita I went to visit Vladamir, one of the few Cuban doctors I knew who claimed to not believe in the efficacy of *curanderos* in any capacity. I recounted the day's events to him, and he laughed and explained to me that these people are not serious healers but are there for the superstitious and the *maleducada*[123]. Later, upon my return to Canada, I wrote to Vladamir and told him about some of the literature that I had been reading about *empacho;* and explained that much of the literature cited *empacho* as a folk illness common among the Latino groups. The response I received was telling.

> You sent me a question about what is *empacho*, and I was laughing at you for a while but in a good way because you are so funny! I will tell you that it is not an illness of the tropics nor latinos nor of anything, because what it is simply is indigestion; and this name (*empacho*) is what the rural people have given it, and fundamentally they cure it with abdominal or leg massage. However, this massage is dangerous because they can break an abdominal vein or one in the legs. They say that the food gets stuck in the stomach, and for this reason it is necessary to detach it. They have an entire ritual where they pinch the skin and sometimes they give a purgative tea or water; that is all, my dear, simple, really.

Despite the fact that biomedical doctors tend to see *empacho* as nothing more than indigestion, it is clear from my research and that of others

(Weller et al, 1991; Weller et al., 1993; Pachter, 1994) that for the majority of patients, biomedicine is not seen as an effective method for relieving either the cause or symptoms of *empacho*.

Many anthropological studies of treatment-seeking behaviour among various social groups state that, given various treatment options, many patients will utilize the services of biomedical doctors while simultaneously seeing an alternative or traditional healer to both diagnose and eliminate the cause and manifestation of illness (see Whiteford, 1999; Garro 1998a, 1998b; Leslie, 1992; Mwabu, 1986). However, in the case of *empacho*, it is the symptoms that are relieved most effectively by the *curandero*. The cause is believed to be the behaviour of the individual who suffers from it. Both the cause and prevention of *empacho* were in every case described to me as being dietary (eating too much in general or too much of a particular food, eating food that is 'too heavy,' food allergies, etcetera), and therefore controlled by the direct behaviour of the individual or the parents of the individual sufferer. *Empacho*, unlike other 'folk illnesses', does not have a cause beyond the control of the individual who suffers from it. In other words, it is not perceived as having a supernatural or religious basis. This, however, is not the case with love sickness or illnesses caused by *mal de ojo*.

Following my interviews with patients and medical staff about

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[123] Uneducated, literally; but also holds connotations of being ignorant and of a low class.

treatment options, Dr. Valdes and I decided to proceed with the next step in our investigations; and visit more of the practitioners that operate outside of the official system.

Curanderos and Religious Practitioners In Alonjas

In Cuba the term *curandero* is used rather loosely to refer to any person who is viewed as capable of curing any number of illnesses. Some persons, such as Isabelita, are referred to as *curanderos* because they can cure a specific illnesses such as *empacho* using a specific technique that is not practiced within the realm of biomedicine. Such individuals do not necessarily have any type of religious or supernatural capabilities. However, there are many *curanderos* who do utilize supernatural forces to effect a cure in their patients, or to break the cause of the illness. During my research with Dr. Valdes, we went to visit two types of *curanderos*, a *yerbera* and an *espiritualista*. Later, through other contacts, I made several visits to two Santeros and a practitioner of Palomonte.

Yerberas

On the streets of the Havana suburb of Alonjas, one does not have to go far to find a *yerbera*. *Yerberas* both sell herbs and offer advice to their customers on which herbs are best suited for which types of illnesses. Dr. Valdes and I went to visit one such *yerbera* named Jore. Jore spends most of his days sitting in a rundown little room whose cracked wooden doors open into one of the many side streets of Alonjas. Many of the herbs that Jore sells can also be purchased in a tincture form in the state-run pharmacies, but Jore sells his herbs in their natural form. Many people prefer to buy their plants in this form because they are seen as being more effective for treating a number of illnesses. Furthermore, Jore explains, the state selection of herbs is very rigorous; and ends up excluding many useful herbs because either they cannot be mass-produced in an efficient way, or because their efficacy does not show up in lab trials. Many religious healing ceremonies, he continues, require that the plants be used in their natural form. Processing is perceived as taking away some of the effectiveness of a plant's healing properties. This, according to Jore, is why people frequent his 'shop.'[124]

Jore explains that he simply sells these herbs to people who do not have the green space to grow plants themselves. Many people, he maintains, do grow some of these plants on their balconies; and their uses are plentiful. The second day that Dr. Valdes and I passed by Jore's shop, he offered to close up and take us on a tour through the streets of Alonjas to show us these plants and teach us about their various uses. The first plant we saw on our tour is a tree called Yagruma. Jore explains that this tree has supernatural powers. It is both good and bad, and as such it embodies both sides of life. If one were to cut down this tree, he warns, the result would be death. After spending most of the day tirelessly

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See Miles, 1998, for a study on herbal shops in urban Ecuador. The shops described in Miles' study more closely approximate the official pharmacies in Cuba than the popular shops described here.

walking the streets, peering onto people's balconies, I came up with a list of some of the plants and their respective uses as described by Jore (see Table 8).

Table 8: Plants and Their Uses as Described by Jore

Plant name	Use
Lingua	For gossips
Cactus	Infection and to make paint
Rosas	To make shampoo when there is none
Romero	A digestive aid, pain in the throat, vaginal douche, tastes good
Romerillo	Intestinal parasites, to make the hair shiny
Quizazo de caballo	Heat rash
Savila	Cold, headaches
Tilo	Calm the nerves
Manzanilla	Calm the nerves
Albahaca	Flu, colds
Plantano	The trunk is used to treat certain types of cancer
Oregano	Bronchitis, gripe (flu), it is easy to grow
Malangas	Skin problems
Violet	Bronchitis, cough
Fruta Bomba	Stomach pain, diarrhea
Mariposa	Smells nice, makes one attractive

Jore explained that while most people know the various uses for the plants and how to take them, they often like to consult with him as well. Furthermore, Jore often collects his plants in the 'proper' way. When asked what he meant by this, he explained that he would often ask permission from the *orishas* (sub-gods in the Santeria religion) to take the plants; and sometimes even leave offerings for *Osain*, the *orisha* in charge of the plants and to *Elegua*, his favorite *orisha*. Jore showed me some of the offerings he had made, which include a small glass of rum, several cigars, an orange, a few centavos, three candles, and two cupcakes with pink icing.

Espiritualistas

Samia is a very elderly woman who lives in a large, dark, and dusty room in a rundown *solar*[125] at the edge of the city with her daughter, her son and his wife, and her three grandsons. Her space in the *solar* is uncharacteristically cluttered with papers, utensils, food, and *bolsas* scattered everywhere. Half-dressed children run through her room playing tag, many of them with skin infections that she tells me are the result of chickenpox. Samia and her daughter, who is currently visiting relatives in another province, are *espiritualistas*. For three pesos (the equivalent of fifteen cents US), she can cleanse people's auras.

Spiritualism or *espiritualismo*, as it is called in Cuba, developed in France in the 1850s under the leadership of Allan Kardec, whose books were translated into a number of languages including Spanish. Within this belief system there is a hierarchy of spirits that are constantly seeking enlightenment, which they are given through the power of a medium (Perez and Mena, 1991). While practitioners of *Espiritualismo* take an anti-Catholic stance, the religion contains many teachings that are based in

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A *solar* is like a group home where people go to live if they have no home or if their home has fallen down. Theoretically, this is a temporary accommodation although I was repeatedly told by Cubans that this is where the poorest people live. Often they wait many years to receive a new home, if ever at all.

Judeo-Christian theology (Finkler, 1983).

Samia quickly offered to clean my aura, with a warning that her daughter is much better at it than she is. I accepted, and she walked over to me and stared me directly in the face. Her eyes appeared to glaze over for a few seconds, until she looked away and told me that she cannot clean my aura because there is nothing to clean. I offered to pay the three pesos anyway but she refused, saying that it would be bad luck for her to take the money if I was already clean. She smiled at me, and told me that my life will be good and that I am very lucky. God loves me, she said.

I asked Samia what sorts of problems people have when they come to visit her. As she pointed to the ceiling, she explained again that she is an *espiritualista* and not a *Santera*. She acts as a conduit for the hand of God that comes down and clears away what is dirtying a person's aura. A person knows that they have a dark spot in their aura if they have unexplained bad luck that she believes to be caused not by *brujeria*, but by one of the many existing spirits that can randomly cause illness to humans.

I asked Samia if she believes that people come to her before or after they have seen a doctor. She said that most people who come to see her or her daughter come there first because they believe in their powers. If they are unable to resolve the problem, the person will either see a physician or they will seek help elsewhere, maybe from a Santero. Samia further explained that the power to *limpia* (clean) is a power that one is born with, but this power must be developed and respected. One can develop and respect this power through living a life of devotion, and through *ofrendas* (offerings) to God and the *santos*.

Religion In Cuba

Archeological evidence traces the cultural influences on religion in Cuba today as far as the ancestor worship and hierarchization of gods characteristic of the Ciboney and Taino aboriginal peoples that inhabited the island at the time of Columbus' arrival in the mid-1500s (Farinas Gutierrez, 1994). More recent influences come from the Spanish immigrants who brought Catholicism, Chinese bringing Confucianism, Nigerians bringing Yoruban; and people from the Congo, Sierra Leone, and other African countries all bringing varieties of their own distinct religions. Other religions include French spiritism, Judaism from Eastern Europe, and even vodoun brought to Cuba in the early 20th century by Haitian workers. As a result of these and other varying religious influences, Cuba quickly became a religious mosaic (Ramirez Calzadilla, 1994a).

Due to political sensitivities surrounding the topic of religion in revolutionary Cuba, and the resulting difficulty in studying its impact and effect on present day Cuban society, comprehensive studies of religious practice in contemporary Cuba are relatively few. Furthermore, much of the available analysis focuses on the 'political oppression' of the Cuban state against the Catholic church and its followers, and pays little attention to the popular religions or the lived experience of religious practice and belief in the everyday lives of the Cuban people (e.g., Short, 1993). In fact, according to Diaz Cerveto et al. (1994:225), "the systematic and multidisciplinary study of the religious phenomenon in Cuba is a recent development that started less than a decade ago."

It is certainly not my intention to provide a comprehensive description or analysis of the role of Santeria or any other popular religion in modern day Cuba, as such a task is beyond the scope of this thesis. However, in order to contextualize the data I collected on treatment-seeking behaviours during my visits to two *Santeros* and a practitioner of *Palo monte,* it is first necessary to provide some historical background concerning the impact and influence of religion on the socio-economic and political development of contemporary Cuba.

The Role of The Catholic Church in Post-Revolutionary Cuba

When the triumph of the revolution was declared in 1959, support for the Catholic Church began to decline (Barton, 1997:13). Almost immediately following the 1959 revolution, 132 priests were expelled for counterrevolutionary activity. Of the 723 priests and 2225 nuns in Cuba before 1959, only 207 priests and 205 nuns remained in 1962 (Bonome Moreno et al., 1994:264). Short (1993) traces the revolutionary government's oppression of religious practitioners, especially those of the Catholic Church. However, an opposing view is presented by Bonome Moreno et al. (1994), who argue that not it was not so much that the communist government of Cuba discouraged religious practice but that the Catholic Church set itself up in diametrical opposition to Cuba's new revolutionary government, forcing out those Cubans who showed their allegiance to the state. What quickly developed was an atmosphere of animosity between the Church and the state. The Catholic Church held on to those Cubans who opposed the revolution, and those who supported the revolution stopped attending church services. The communist government initially prevented self-proclaimed Catholics from holding certain jobs, attending university, or from being communist party members. This treatment led to a societal mistrust of Catholics as counter-revolutionaries.

In the late 1960s, the Church began to restrengthen its ties with the state, in an effort to maintain its importance. Since the churches themselves were never shut down, an atheist society never developed (Bonome Moreno et al., 1994). By 1991 the revolutionary government changed its position on Catholicism; and Catholics were allowed to become party members, clergy could be elected to the National Assembly; and in December of 1998, Christmas became officially recognized as a holiday. According to Bonome Moreno et al. (1994), due to the initial ideological stance of the Catholic Church, peoples' religious needs were channeled towards religious expressions that lacked political-ideological elements. Such religious expressions were easily found in the African-based religions of Santeria primarily; but also in some of the less popular religions such as *Palomonte, Espiritualismo,* and Protestantism.

Today, religion in Cuba remains without a strong institutionalized base. A recent study conducted by the Department of Socio-Religious Studies in Cuba states that only 14.2% of the 4,485 Cubans surveyed hold religious beliefs that place them into a particular system, and the same number can be considered non-believers. The remaining population holds beliefs and practices that are expressed individually in a way that is independent of organized forms of religion, with no one religious expression appearing to predominate over all others (Diaz Cerveto, 1994).

It is the presence of a religious consciousness, but with a relatively low institutional infrastructure, that accounts in part for the heterogeneous and syncretized nature of many Cuban religious practices. According to Jorge Ramirez Calzadilla (1994a: 196), religious forms of African origin acquired their own characteristics that are distinct from the original African religions; and have extended themselves throughout the poor population regardless of race. In a separate paper, he argues that Cuban religion is characterized by syncretism, crossbreeding, and migration that have blurred religious and ethnic divisions (1994b). This is why, despite the fact that many African-Cuban religions are obviously based in African traditions, this feature is not necessarily reflected in the make-up of the devotees. Of the plethora of religious traditions that exist on the island of

Cuba, Santeria, or worship of the saints, is the most popular; and probably the most researched form of religion in contemporary Cuba.

Santeria

The word Santeria means 'way of the saints.' Santeria has been defined as "a religion that developed in Cuba from the sixteenth to the nineteenth centuries as a syncretism of African religions, Roman Catholicism, and French spiritism" (Lefever, 1996:318). Furthermore, Santeria is said to be the most structured and influential of the Afro-Cuban cult organizations (Sandoval, 1979:137).

More commonly, Santeria is talked about as a syncretization between the Yoruban religion of southwest Nigeria and Roman Catholicism. Most Cubans talk about Santeria and Catholicism interchangeably, exceptions being the more devoted followers (in terms of institutionalization) of either religion. Many accounts in the literature describe the syncretization process as having begun during the early days of the slave trade, when African slaves had to hide their discouraged or forbidden religious practices by disguising them as Catholicism. As a result, today most African *orishas* have a corresponding Catholic saint. In Santeria, *orishas* are intermediaries to the high god (Olodumare) to which people, namely Santeros, have access. There may be up to 1700 *orishas* (Murphy, 1988:12); but in Cuba there are 16 major *orishas*, each with a corresponding saint. The *orishas*, like the Catholic saints, have human forms, emotions, and virtues; but unlike saints, they are also capable of causing great harm when displeased.

Table 9: The Sixteen Main Orishas in Santeria

Orisha	Saint	Characteristics
Agayu	Christopher	Fatherhood
Babaluaye	Lazarus	Illness - can cure and cause leprosy, smallpox, syphilis, gangrene, skin ailments, and other infectious diseases - the miraculous healer.
Elegua	Niño de Atocha, Anthony of Padua	Wayopener, messenger, trickster - the lonely soul of purgatory
Ibeyis (twins)	Cosmus and Damien	Children - prosperity and good fortune
Inle	Rafael	Medicine
Obatala	Our lady Mercy/ Mercedes	Clarity - he is Olodumare's oldest son and the king of the *orishas*. He has curing powers, especially in paralysis and blindness, which he can also cause.
Ogun	Peter	Iron - only priests initiated into his cult can perform sacrifices of four-legged animals - punishes by causing accidents
Olokun	Regla	Profundity - deep levels of the ocean - always wears black
Orula	Francis	Wisdom, density. He is a great physician and counselor - the priests of this *orisha* are Babalaos - punishes with mental disorders.
Osain	Joseph/ Sylvester	Herbs, wild flowers, and plants - if not properly rewarded will make the herbs ineffective
Oshosi	Norbert	Hunt, protection - punish by putting in jail or reward by expediting a quick release (more in Miami)

Oshun	Caridad	Eros, rivers, love, and all things sweet - most popular female *orisha*- Shango's third wife - can cure and cause illness to the genitals, lower abdomen, and blood.
Oya	Cadelaria	Death, thunder, ill wind, and tornadoes - she is Shango's second wife - protector of the cemetery - kills by electrical discharges and accidents caused by wind and storms.
Shango	Barbara	Force, thunder, fire - he is the most popular *orisha*, has the most exuberant and irresponsible qualities of masculinity - can cause death by fire
Yemaya	Regla	Maternity, seas, the upper level of the ocean - Queen of all *orishas* - protector of sailors and fishermen - can cause and cure intestinal disorders and tuberculosis.

Ref: Lefever 1996:320; Sandoval, 1979:138-140; and my own research.

There is much debate as to how much of Santeria is in fact syncretized with Catholicism.[126] For example, both Apter (1991) and Thompson (1983) argue that practitioners of Santeria did not use Catholicism simply as a way of hiding their worship of the African *orishas* from official persecution, but as a way to take possession of Catholicism and thereby repossess themselves as active spiritual subjects. Davis (1995a) points out that many Yoruban customs, prayers, and expressions no longer present in Nigeria and other African countries, persist today in Cuba. However, as previously stated, many Cubans who did not have a strong religious affiliation with either religion expressed to me that they think Santeria and Catholicism are syncretised. For example, in one interview I told a Cuban patient about a statistic that I had read which stated that 85 per cent of Cubans believe to some extent in Santeria. He responded:

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[126] See DeHeusch 1995 for a similar discussion of the syncretization of Vodoun in Haiti.

> I think that maybe it is not that much. And also there are many people who don't know what Santeria is - it is like Catholicism, and Catholicism has many things that are Santeria too. In Cuba it is very mixed; but I don't know what percent, but I would say a very high percentage of the population in one way or the other believes in something. You know there are people who tend to believe everything they hear or everything they see; and there are people who find it more difficult to believe; or they don't believe anything or everything they need to see or prove themselves. And I think that it is more for those people who are open to believe everything. For many, they like the ceremonies and they believe in that. Do you see people who have glasses of water in their homes that are just sitting out? Have you seen that in the homes you have visited?
>
> Yes, I have seen that.
>
> Well, this is a form of this; and most people believe in some of this, and it doesn't mean that they are Santeros or believe in Santeria or anything. Even Catholics do these things.

Evidence of the *orishas* can be found throughout Cuba. For example, red ties of cloth can be found on rearview mirrors of cars, symbolizing the protective powers of Elegua. At a cemetery, offerings of vegetables are left for Oya in return for her protection of the dead. Under seba trees one can often find glasses of rum or water and fruits made as offerings to the *orishas*. Furthermore, Santeria beads, representing initiations into the various cults of the *orishas*, can be seen around the necks and wrists of many Cubans.

Santeria is a hierarchical religion, with Oldumare being the supreme God, followed by the *orishas*, spirits of the dead, and animistic charms (such as shells, pieces of coconut, beads, seeds, etcetera) in that order. The charms are used as tools of divination, and are read by the priests of Santeria. Practitioners of Santeria make offerings to the *orishas* in exchange for various favours. Each *orisha* has particular objects or animals that should be made as *ofrendas* for the use of their powers. For example, Shango only receives male animals, Yemaya prefers white animals, and Oya receives green peppers and other vegetables. In a Santeria ceremony it is the *ashe*, or the life force, of the offering that is made to the *orishas*. The participants will generally consume the rest. During such ceremonies, repetitive drumming will often occur until the priests of Santeria are able to enter a trance through which the *orisha* may communicate with the individual who is seeking out their services. When the Santero becomes possessed by the *orisha*, the Santero is said to be the horse; the *orisha* mounts the horse in order to control its behaviour.

Santeria and Health Care

Mercedes Sandoval (1979) has traced the development of Santeria as a mental health care system. In her article she argues that in pre-revolutionary Cuba, many Cubans lacked access to health care, especially for mental illnesses. While psychiatrists were available in institutions for those deemed to be mentally insane, psychologists and counselors were almost unheard of, especially for the poorer classes. As a result, persons looked to religious institutions to provide not only standard health care treatments but also for mental health support. Once health care became accessible to the poorer classes, which were predominantly African-Cuban, the importance of Santeria and other religious systems as the sole health care providers became diminished. However, the importance of Santeria for solving problems of a spiritual and emotional nature remained. In its shift toward the treatment of personal crises and emotional problems, Santeria assumed the form of a coexistent rather than an exclusive health care delivery system. As such, Santeria spread in popularity throughout the population, instead of being concentrated in the African-Cuban population.

In Cuba, Santeria does not hold to any rigid doctrine; and does not appear to apply pressure for religious exclusivity (Diaz Cerveto, 1994). Likewise, Sandoval (1979) argues that the use of Santeria as a healing system among American Cubans in Dade County, Florida, is not seen as conflicting with the dominate western biomedical system by those who practice it. In fact, she argues, Santeria is seen as a flexible system that can collaborate with biomedicine in treatments of mental illnesses. Likewise, in my own research, I found Santeria to be almost void of dogma. The lack of demands for strict adherence to any one form of religious practice by the majority of Cuba's religious traditions has created a situation in which several healing traditions can coexist in relative harmony.

Phillipe

Phillipe calls himself a Babalao, or a priest of Santeria. Phillipe is not of African descent, and he points out his *ojos claras* (light eyes) to prove it. He was raised a Catholic; but as a child he had an Afro-Cuban nanny who taught him many things about Santeria, and he often accompanied her to various Santeria ceremonies. It was at one of these ceremonies, when he was only nine years old, that a high priest of Santeria told him that he had the mark of a Santero; and it was his destiny to become a Babalao. I interrupted Phillipe to tell him that I met a little girl of only four years whose mother told me that she was a Santera, and asked him how this is known. He explains that it is not always up to the individual; sometimes the person is chosen by an *orisha*. "If you are chosen, you must be initiated; and you must respect your *orisha* by making *ofrendas*; otherwise something bad may happen to you."

Phillipe appeared to be weighted down with necklaces of varying colours, each representing a different *orisha* and a separate initiation ceremony that he has undergone. He told me he has been initiated into every cult of Santeria, and is therefore able to draw on the powers of any of the *orishas* to assist those who come to him for help. I asked Phillipe if I could record our interview, and he said that it was up to the *orishas*. I waited while he looked for a small black velvet bag containing several small shells. He took the shells out of the bag and tossed them on the floor at the foot of a statue of Elegua. He told me I could record but that I cannot take any pictures because Elegua is in a bad mood today.

According to Phillipe, approximately 70 per cent of Cubans practice some form of Santeria; and some biomedical practitioners send their patients to him when the illness is seen as something that Santeria is better able to deal with.

> Most physicians are religious people too, and sometimes they say your problem is not for a physician. They say "you go to a priest to tell you how to manage, how to fix yourself because this is not my problem." The physician cannot do anything more; and so they send them to a Babalao, to a Santero, a Palmero, to different ones because they are all different branches.

I asked Phillipe to tell me about the use of Santeria as a healing system; and, in typical Cuban fashion, he began to recite anecdote after anecdote of how the knowledge and practice of Santeria can cure many things and solve many problems.

"When I was a child," he began, "my family was very wealthy and my father was a very well-respected doctor; but always I was cured by my nanny, who would make me teas and feed me herbs. She had this knowledge from her African ancestors."

I asked what he meant by ancestors; and he explained that his nanny was taught by her family when she was a little girl, and today she continues to be taught by communicating with the spirits of her family in the afterlife. Phillipe then continued to tell me stories of persons who have come to him looking for help with their various illnesses. During some of his anecdotes, he got up to show me a plant that he uses to treat the particular illness he is discussing.

I asked Phillipe where he thinks the knowledge to heal in Santeria originates:

> I suppose it was a mix between the Indians and the Africans; because the Indians, the first time they taught the Africans how to use the knowledge of the earth here; because they came from Africa, they had their own system, their own plants; and the Indians they worked together, together with the Africans. And so I suppose it was the Indians who taught the Africans to use the plants. This was in the 16th century, and so they began to teach them, and so that is how we know. You can go to any, not just Negroes, but any person that practices the religion; and they will tell you that in Cuba, we are mixed, a big mixture of everything - that is the Cubans.

Phillipe continued, telling me that today Santeros who are initiated into the cult of *Osain*[127] are specialists in herbal treatments.

> There are men who are called *osainista* which are specialists in knowing in which moment you have to take the roots of the herbs and everything, at what time, at what hour, at what moment; and so it affects them. These people have to ask permission with the *caracoles* to take the plant; you cannot just take it because it is a life too, so you must ask permission; and maybe they say no. And that is why the *osainista* is very important in every ceremonial in this religion. In every case he is very special because he is the one who must know at what hour, at what time, and how he is going to ask this herb to take it.

Phillipe explained that while he thinks it is good that herbal medicines are now being used in the official health care system, he recognizes also that it contradicts the principles formerly espoused by the Cuban government, as well as those who practice biomedical science.

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[127] The *orisha* of the herbs and the plants.

> These people, who have this knowledge, they are now being reborn by the government. I find this very curious. They said that *medicina verde* was *brujeria*, witchery, and everything; and we were all witches because I always solve my problems with green medicine when I can, not always, but when I can. They said it was terrible, it was witchery; but now they have to give us *medicina verde* because we don't have medicine and now we all solve everything with *medicina verde*. That is funny, right?

While Phillipe believes that Santeria is practiced differently in different parts of the island and in other countries, he does not believe that Santeria is a religion that has been syncretized with Catholicism.

> They speak Yoruba in these places where they have the ceremonies. Catholicism was just to hide the religion, but Santeria and Catholicism? They are very different. Indeed they are not the same; one has nothing to do with the other.

In Phillipe's healing ceremonies, the *orishas* are called upon to use their powers to help the person who is suffering. The *orishas*, he explains, act as intermediaries to Olodumare, the supreme God. He emphasizes that Santeria is a very practical religion that works to solve problems and provide divination. The *orishas* must be kept happy at all times. Otherwise they can inflict harm upon you, possibly making you ill with the very illnesses that they are best able to cure.

Linette

Linette is an elderly Santera who told me she has been practicing for more than 50 years. Linette, like Phillipe, became a Santera when she was very young. When Linette was only thirteen years old, she became very ill.[128] Her parents, who were devoted Catholics, took her to many different doctors; but they were unable to help her, and told her that there was nothing wrong with her. Finally, one day her grandmother took her to see a Santera who lived on their street. Linette stated that the Santera performed an elaborate ceremony for her in which they sacrificed a chicken and made several offerings of rum and vegetables. The Santera became possessed during the ceremony in order to mediate for the *orishas* who were best able to heal her. During her possession, the Santera's son came to her as a spirit and made the mark of a *santo* on Linette, sealing her destiny to become a Santera.

Today, Linette has the gift of being able to see the spirits and the *orishas*. The walls of her modest home are covered in paintings she has made of these visions. She pointed to them and told me they are of Yemaya, Babaluaye, Osain, and Shango. I asked Linette how she treats people who come to her with illnesses. She explained that she cures many things. Usually she gets San Rafael to prepare the medicine, and Osain chooses the herbs. She makes an offering to Osain whenever she collects the herbs, to ensure that they will be effective. "I collect *manojos* of herbs (as she holds out her hands in front of her); I do not measure by a cup or a litre as they do in the pharmacy. We measure by *manojos*."

The *orishas* often communicate with Linette through her dreams. She told me that sometimes the person has a problem that is best dealt with by a doctor, and in such cases she sends the person to a doctor. "But there are problems that the doctors cannot help you with," she explains. I ask her for some examples.

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[128] According to Finkler (1998), practitioners of *Espiritualismo* in Mexico have usually experienced some sort of illness prior to becoming healers.

> I can cure circulatory problems, lice, fungal infections; but mostly I do spiritual problems that cause harm. I can also cure impotence in men. First I send them to a doctor; and if the doctor cannot help, then I know it is because someone has used some *brujeria* against this person. It is the same, for example, with problems with *brujeria;* in this religion *algo brujeria es malo* (some witchery is bad) and it makes the person sick; but the doctor doesn't have anything for this, and so *yo saco eso de estomago* (I take this out of the stomach).
>
> *You take something out of the stomach?*
>
> I give him something to take it out of his stomach.
>
> *How does he get it out?*
>
> When he goes to the bathroom. I do many things!
>
> *Do you diagnose too?*
>
> Yes, sometimes you have something above you, a spirit that the doctor is not permitted to see. He cannot see what you really have; and so I do a ceremony, a ceremony like the one I did for José to clear him of this organism. *Para limpiar* - you know now what this means?
>
> *Yes, I think so - to clear away; to clean it.*
>
> Yes. The doctor cannot see with an examination what has happened to him.
>
> *Do the doctors ever send their patients to you?*
>
> No too often here; but in Nigeria, yes.
>
> *So they do not send patients here even if they cannot help the patient?*

> Well, I have one psychiatrist friend; he is a doctor, and he sends the patients here if he can do nothing. Sometimes I must make a ceremony to untie them.
>
> *To untie them?*
>
> Yes. For example if a man wants to be with you and you do not want to be with him, and he makes a ceremony to tie you to him, you will then have to untie yourself from him. Like what Celia did to José.
>
> OK.
>
> Some of the people that come to see me are doctors, some architects - all professions. They come for help in their work, their lives, and especially in their relationships. You know I told you that the mind is the greatest factor affecting health - people want things, and if they can't have them they hurt. People feel emotions strongly that cause their health to suffer. I cure problems within peoples' relationships that can affect their health negatively. I make them stand in the middle of a circle of fire, and I enlarge the flame with alcohol. If the fire raises, the answer is yes - the person jumps and it *limpia lo malo entre esta circulo* (cleans the bad inside the circle).

The ceremony that Linette is referring to is one that she did for a friend of ours who was married to a woman whom Linette described to me as "not a nice woman." She had two personalities, she explained. José did not want to marry this woman; but she performed a ceremony that tied him to her, and this made him feel an unexplainable connection to the woman, to the point where he even committed himself to her in marriage. Linette explained that this is a bad thing to do because people should be with people because they want to; but in Santeria, she explained, there is no free will. So Santeria can be used to manipulate the will of others.

I asked Linette about the relationship of Santeros and Cuba's official public health care system. She told me that she has a good relationship with the public health care system. Her doctor is very nice, and the doctors can cure many illnesses. However, she explained, "we know many things that the Ministry does not know; we can get rid of some things that the doctors cannot see."

> *Linette, where does this knowledge that you have come from?*
>
> The Africans brought much knowledge and plants here; and also the Indians and the Spanish, from all parts. They all used the plants to cure because, well, the Spanish would cure their families, all of them. They cured themselves. It was within the families as it is their customs. They also discovered the customs of others. The Spanish discovered the customs of the Africans, and they learned from each other. Even the French too and the Italians; they have their customs. The Indians and those from Kenya and Angola too, many parts.
>
> *Now in Cuba, they are using medicina verde and other forms of traditional medicine in the clinics. Where are they getting this information?*
>
> From books. These books are the books of the Africans, but they don't say everything. They don't say some of the stuff that we know. We have something that they don't have. Do you understand? They don't say that it is a conception. I have said that but they don't use the conception. You know the difference, don't you?
>
> *So they only use some of the information, what is useful or makes sense to them?*
>
> Yes, they only use what they say is science; but they miss some important knowledge that only we have.

Palomonte

Palomonte, while not as well-known or studied or even practiced as Santeria, still remains a powerful influence and source of healing for many Cuban people. According to Sandoval (1979), Palomonte, also called *kimbisa*, has its origin in the Congo and Angola. It was brought to Cuba by Bantu-speaking Africans. The members of this religion are said to be quite respected and feared, since they have a reputation for being very effective in their practice of malign magic. When I arrived in Cuba, I had heard of Palomonte only in passing references and knew of it only as a religious practice, like Santeria, only less popular. When I was presented with the opportunity to visit a priest of the religion I eagerly agreed, despite the fact that he lived quite some distance away, and I felt very unprepared. Before I left for my interview, I asked Enrique, the only Cuban whom I knew who participated in Palomonte ceremonies and rituals, if he could describe Palomonte to me and its role in healing.

> You know about this Palmero, there are many Palmero, it is sort of a tribe. There are many Palmero, Yang-Yigo, Yoruba, many different ethnics here; but this group, they have this system that uses different roots and leaves from different trees or plants; and they developed this system to cure many, many diseases. What happens with this? What makes it different from Chinese medicine? In the Palomonte rule you have all these different stories about spirits; and you know, ah, many holy ghosts that you bring down when you diagnose; and the holy ghost is supposed to know more than you because he is on a different plane of existence so he can travel away; and he knows exactly what the herbs are, and that you eat them like this. And so when they work, when they try to make this soup (laughs). They are boiling all of this together, and it is so disgusting, and people think it is crazy. They say "Oh come on!", but they

> cure with that; and so you say "How come?"; and we say, "Oh, OK explain it to me, what chemistry is this? How do we combine this with that?" but this way you will never get to know the way [of Palomonte] because for them either you believe or you don't.
>
> It is weird, but it doesn't matter if you believe or if you don't – you are going to suffer the consequences if you take it, like if you are ill and you take it. They are very well prescribed drugs – but they cure, so what do you do then? To go, to surrender to this whatever – this holy ghost in charge. How do you explain that through the western medicine that we know? Through chemistry? For me none of this will happen – you don't need to do that. You instead need to listen and you know, to take notes maybe; ya, here we have a lot of that.

Len

When I finally arrived at Len's home, it was around eleven on a hot Sunday morning. In front of his house stood a statue of Santa Barbara surrounded by rattles, red and white beads, and other charms, and objects normally attributed to the Santeria *orisha* Shango. As I stood there making a mental note of the statue, and thinking that it seemed to be a common thing to find in the home of a practitioner of Santeria, out of the house came a very dark, very tall, and very elderly man, dressed completely in white. He beckoned me to enter the house, explaining it was much to hot to be outside. I followed him through his living room and into a large kitchen area with a big wooden table. At the table were two middle-aged men and a young woman of approximately thirty. He asked me to sit; and I presented him with a bottle of *aguadiente*, as I was told to do, by Enrique. He then did what I hoped he would not do; and pulled out a big plastic red cup and filled it almost half full of the strong alcoholic drink, and passed it to me. Even though I cannot stand the taste of aguadiente, and I felt it was quite early to be drinking anything that was more than 50% alcohol, I did not want to be rude; and so I sipped slowly at the fiery liquid as we conversed about the nature of his beliefs and his healing practices.

I pulled out my tape recorder, and was about to ask if I could record our conversation when I noticed the nervous expressions on the faces of the three people around the table. Instead, I said that I would just take notes. I explained to everyone that I was interested in learning about systems of healing outside of the official practice in the clinics and hospitals. Everyone then seemed to relax, and an animated conversation began. There were several interruptions from all four persons, with stories of various illnesses that they, or a friend, or a family member had had, that Len was able to resolve.

For example, Anita, the woman at the table, told me of a time about five years ago when she first got married; and she and her husband were trying to have a child. For two years they tried to conceive a child, but were unsuccessful. The doctors said that there was nothing wrong with her or her husband, and that they could not understand why they were unable to conceive. After visiting several doctors, she decided that she would pray to *La Meligrossa* (the miracle). *La Meligrossa* is a large tomb in an enormous cemetery[129] in Havana with a statue of a woman who was said to have died, along with her child, during childbirth, while her husband was away. The woman and her child were buried together, with the child at the feet of the woman, as is the custom in such an event. When the father returned, he was said to have been so overcome with grief that he dug up the grave of his wife and child; and found the baby in the mother's arms, suckling at her breast. Today the statue is known by many Cubans as having supernatural powers for women who are unable to conceive, and many Cuban people pray to her for help in conceiving children or when their children are sick. I have heard countless stories of *La Meligrossa,* and how she has performed numerous miracles for many Cuban people. However, *La Meligrossa* did not solve Anita's problem. She explained that this was a terrible time in her life. She and her husband were fighting often; and she had almost given up on making her marriage work, until finally, a neighbour told her about Len and his healing powers, and suggested that he may be able to help her.

When Anita came to Len, she was desperate; he was her last hope. She explained that Len performed a ceremony whereby he channeled the powers of *Yemaya,* who told him what Anita's problem was. It seems that an ex-girlfriend of Anita's husband was very jealous of Anita and her marriage, and had performed a ceremony using *Yemaya* to cause Anita to be unable to conceive a child. Following the ceremony, Len touched the bottom of her feet to see if they were cold or hot; and then he rubbed a cream into her leg until he found a *pelota* at the top of her thigh. Once Len knew the problem and how it had manifested itself in Anita's body, he was

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[129] This is the second largest cemetery in the world.

able to suggest a ceremony to break this tie; but Anita would also have to make several *ofrendas* to her own *Yemaya*. In addition, Len made a mixture of coffee, milk, and wine that Anita had to drink. She also had to keep orange leaves on the bottom of her feet until she was able to conceive, which, she tells me, happened four months later.

I said that I thought that *Yemaya* was an *orisha* from Santeria, and Len explained that Palomonte practitioners use the *orishas* too. They have others as well, but they are secret. There are many differences and many similarities between Palomonte and Santeria. The main difference, he told me, is that Palomonte is not as influenced by Catholicism.

After listening to several stories of Len's capacity to heal, Len took my book and wrote the following in it:

Babalawo - sacerdote africano[130]
Abakkuá - solo por los hombres (Hermanado de socorro mutuo donde no se pueden revelar los secretos de la religion)[131]
Regla de ocha - santo[132]
Tat nganga - palo monte - bantú[133]

Len told me that his parents were both followers of Palomonte; and that everyday, the number of Cubans who believe in the 'African religions' is increasing. He explains that this is in part because the Catholic church does not have the same influence and power in Cuba as it does in other countries. The Catholic church lacks political power, he said;

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[130] A Babalawo is an African "shaman."

[131] Only for men – united in mutual help where you cannot reveal the secrets of the religion.

[132] This is the name of a saint.

[133] Palomonte originates with the Bantu people.

and it needs this if it is to recruit as strong a following as it has in other Latin American countries. Len told me that doctors, and even politicians, in Cuba recognize that he has healing powers; and visit him for help. One of the things he is very good at curing is lymphangitis, for which he uses *Caisimón*.

Len asked me if I wanted to see his altars. I told him I did. He told me I could write about them but that I could not take a picture of them. I agreed, and he led me into a windowless room with dark gray walls behind the kitchen. As soon as he opened the door, a waft of what I think is tobacco smoke hit me in the face. Once I could see more clearly, I saw that it was not just tobacco, but incense; and something inside a black iron pot that looked like burning dead leaves. Len walked me past several small black altars to a much larger one in the back corner of the room. It reached almost to the ceiling, with a wide base; and tapered toward the top. It was completely black, and appeared to be covered in tar. I could recognize feathers and entire wings of birds that seem to be pasted to the altar with the tar-like substance. There was an image of a face in the upper-middle section of the altar that appeared to be carved into a stone-like material. There were leaves and roots of plants, stones, fruits, vegetables, and pieces of wood, either pasted to the altar in the same manner as the bird wings, or lying at the base of the altar. Also at the base of the altar was a medium-sized pot smoking over a slow-burning plant of some sort. There was a black cup of what I think was rum or aguadiente, a black dish with both Cuban pesos and American dollars and cents in it, and several large partially burned cigars. Beside the altar was a metal drum, standing almost a meter high, which was filled to the top mostly with small bones, but also with feathers, shells, and stones. Len told me this is where he performs most of his ceremonies. I wanted to look around the room more but I felt dizzy from the temperature, the smoke, and the sweet but strong odor of the room. So I quickly sketched the altar in my notebook and made my way back to the door. Len explained that the smoke helps the *orishas* to possess the horse in his ceremonies. The objects are *ofrendas* made to the gods and the *orishas* in exchange for their assistance.

Conclusion

The legacy of an officially atheist state does not appear to have had much of a detrimental effect on the presence of magico-religious healing traditions found in the unofficial system. However, practitioners do feel that their practice is more accepted by the government now than it previously was. It seems that the official discouraging of religious healing traditions was strongest immediately following the revolution, when relations with the Catholic Church were at their worst. In fact, the Centre for the Study of Social Sciences in Havana published a short book in 1983, listing a number of 'folkloric' cures for various ailments provided by elderly *campesinos*. The book begins with a prologue by the editors, referring to many of these remedies as 'absurd' and 'scientifically unjustified,' while others have potential for advancing medical science (Seoane Gallo, 1993). Likewise, in Nicaragua, during a similar revolution, the Sandinista government viewed *creencias*[134] as obstacles to the provision of good health; in fact, an early health education leaflet portrayed *creencias* as a witch who was overcome by being stoned by the people (*Jornadas populares de salud*, 1992).

There seems to be a general consensus that religious activity in Cuba is on the rise. Both the Santeros and the Palomonte priest told me that they have had an increase in clients since the commencement of the Special Period. All believe that this is not only because there is now more official tolerance, but also because of increasingly hard economic times which are creating more problems for the average Cuban person. Even within Catholicism, numbers are increasing. According to the Archdiocese of La Habana, the number of baptisms in the country was 19,711 in 1980, 26,534 in 1985, and 33, 569 in 1991. The number of seminarians was 36 in 1985, and 58 in 1992 (Bonome Moreno et al., 1994:267).

Within the religious healing traditions in Cuba, there are forces more powerful than human will, belief, and action; and these forces are seen as having control over certain outcomes, such as whether a cure will be effective for a certain illness. Therefore, it is necessary, in order to cure such illnesses, to behave in a manner that is favorable to the controllers of these forces. In Santeria and Palomonte, this is done most often through making *ofrendas* to the *orishas*, but also through initiation ceremonies. In Catholicism, this is done mainly by following a set of moral guidelines of how one should live; but *ofrendas* are also made to the saints.

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[134] From the verb *creer* meaning to believe. It is generally used the same way as *curandero*.

Dogmatic commitment to only one set of beliefs, and to the idea that truth is single and exclusive, is characteristic of monotheist religious expectations (Lewis, 1993:212). The Cuban religious experience is not typically monotheistic. Even for Catholics, the saints are revered and given almost god-like positions in their religious cosmology. Likewise, explanatory models of illness held by individuals are influenced in large part by cultural beliefs, behaviours, and values. Usually an individual's model is a conglomeration of such ethnocultural beliefs, personal and idiosyncratic beliefs, and biomedical concepts. Very rarely are explanatory models exclusively 'lay' or 'popular' on the one hand, or wholly 'scientific' or 'biomedical' on the other (Pachter, 1994:690). Furthermore, in Cuba, an individual's model often changes, depending on the nature and context of the illness episode. Furthermore, biomedical science in Cuba is generally not an exclusive practice; and doctors and nurses, as well as their patients, remain open to alternate views and interpretations of illness causation and treatment.

It is clear that Jorge, Linette, and Len, like many of the patients I interviewed, believe that Santeria can cure certain illnesses that fall outside of the realm of biomedical science. Furthermore, they believe that the knowledge for these alternative healing systems comes from various countries of origin, especially but not limited to, Africa. Hannerz (1996) has argued that cultural acquisition is in part the product of cultural organization. Cubans of Spanish or other non-African descent still had access to African culture and were exposed to African religious practices in pre-revolutionary Cuba through African-Cuban servants; and today, through African-Cuban neighbours, doctors, teachers, patients, and friends.

Hahn (1995) provides substantial evidence for the considerable influence of the mind, social relationships, and social organization on the experience of sickness and healing practices. He defines sickness as "unwanted conditions of the self, or substantial threats of unwanted conditions of the self" (Hahn, 1995:22). Hahn defines three ways of understanding illness: disease accounts, characteristic of biomedicine, in which the body is seen as the cause and remedy for all illness; sickness accounts, in which the person is seen as the cause and remedy for illness; and disorder accounts, characteristic of traditional Chinese medicine, in which the imbalance is seen as the cause and remedy of the illness. No method of understanding illness is better than the other; they are only different.

Vuori (1982:129) claims that even in countries deeply permeated by the scientific-technological approach to medicine, the population still cherishes many traditional healing practices and relies on traditional healers to a greater extent than is usually realized or admitted. In Cuba, it appears that the failure adequately to address spiritual/cultural factors within the official sector has resulted in the persistence of healing practices within the unofficial sector. Furthermore, for doctors, religious practitioners, and their users alike, the presence of such alternatives is not perceived as being in conflict with the official system; but rather just as providing another treatment option. As a result, the majority of patients, when asked, stated that they would interchangeably see a *curandero* or a medical doctor, depending on the nature of their illness. In general, biomedicine is perceived as being very effective in providing treatment for illnesses with an organic cause, whereas the majority of alternatives are viewed as being more effective in treating illnesses brought about by the manipulation of supernatural forces. Similar findings were made by Tola Olu Pearce (1993) in her study of the Yoruba of southwestern Nigeria. She has found that the gap between lay and professional knowledge, characteristic of western science, does not exist for the Yoruba. She argues that biomedicine does not account for the social relations of illness that are an important factor in the healing process for the Yoruban people.

According to Garro (1998b), treatment-seeking is informed by cost, severity of illness episode, type of illness episode, source of illness episode, accessibility, knowledge and possession of a remedy. For many developing nations, accessibility and cost favour treatments that can be found outside the realm of biomedicine; but in Cuba accessibility is not an important factor, since practitioners of all health care options are relatively accessible. Furthermore, at the level of the individual, cost would be a factor working against the unofficial sector, as some religious healing ceremonies are almost prohibitively expensive, and the cost of making *ofrendas* can sometimes become overwhelming.

Chapter 7: A Framework For Organizing the Diversity in Health Care Pluralism

In this chapter, a framework for organizing the diverse meanings and functions of health care pluralism is developed. The framework demonstrates how health care systems and their structural reforms are understood and practiced at global, national, local, institutional, and individual levels; and how constraining factors (political, economic, social, and cultural) affect relationships and interpretations of health care provision and treatment-seeking behaviors at various levels of practice. The current health care reforms and their effects on available treatment options in contemporary Cuba are used to illustrate how a health care system can be plotted within a three-dimensional typology of health care models. This chapter also addresses the potential usefulness and problems of a universal model of health care pluralism.

Theoretical Grounding

The major focus of my thesis is the relationship between personality, culture, the state, and health care in Cuba. I have paid additional attention to the role of globalization in local social policies, and how this affects the delivery or reception of health care at the individual level. Any model attempting to broaden our understanding of such issues must remain flexible and open. It is therefore important to remember that this model is not fixed or static in its nature, but one that is developed with the intention of aiding in our understanding of treatment-seeking behaviors and pluralistic systems of health care. Thus the factors dealt with in this framework are constantly changing as new meanings and functions are negotiated at all levels of practice. As a result of these dynamic and complex interrelationships, new factors and dimensions may present themselves. It is not my intention to disregard any new factors or discoveries; but to develop a model that can grow and develop with each new discovery, each new insight, and each new understanding. This, I believe, is in the true spirit of any academic pursuit.

The theoretical foundation for my framework comes from cognitive anthropology. The primary axiom of cognitive anthropology is the belief that the structure of mind is more or less invariant, while its content differs (see Bock, 1996: chapter 10). One of the earliest founders of cognitive anthropology, and perhaps one of the most important contributors to psychological anthropology as a whole, is Anthony Wallace. Wallace was one of the first anthropologists to recognize and address the role of the individual. In *Culture and Personality* (1961), Wallace reflects on the problems that arose in his earlier conception of modal personality; and struggles with the resulting question: how can people with differing personality types live and function as a society? In attempting to answer this question, Wallace argued that society does not function in terms of a 'replication of uniformity' model, but rather what he called the 'organization of diversity' model. Wallace laid out his model as a challenge to the notion of the homogeneity of culture and its replication among individuals, arguing that cultures do in fact allow for a great deal of diversity in interpretation at the cognitive level of the individual living within the boundaries of any culturally-organized society. Successful interaction, therefore, does not require a shared personality or worldview. However, perceptions and individual cognitive models, while not necessarily similar, must be congruent and predictable for a society to function. In fact, if actions and beliefs were identical, argues Wallace, a society would probably not function.

According to Wallace's organization of diversity model, customary behaviour is the organizing factor that allows individuals with varying cognitive models, or mazeways, to function in a coherent and organized fashion. Wallace recognized that the rules of appropriate behaviour are not fixed; they change and evolve with the negotiation of individual models of reality. Individuals need to develop effective coping strategies to function in society; and so roles, as such, are constructed by societal expectations; they are not automatic reflections of personality. To understand how personalities develop requires the study of socialization (the process by which individuals acquire their motivational structures) and enculturation (acquisition of values and other aspects of culture).

Institutions such as religion, myths, and the symbolic system of a culture (and health care systems) give the impression that there is a shared set of values and beliefs within a given society. Wallace argues, however, that this is not necessarily the case. Individuals with different personalities, values, and beliefs may act in a customary, appropriate way because of societal norms. Although the behavioural expression of societal norms is considered by some to constitute culture, cognitive anthropologists such as Wallace feel it is more fruitful to view culture as an internal phenomenon that provides an individual with a model of societal expectations. Viewed in this way, behaviour is informed more by an individual's model of culture than by his/her personality, which includes idiosyncratic tendencies. Moreover, generalizations about people based solely on behavioural data do not allow for prediction or any relevant theoretical understanding of human nature. Wallace argues that we must try to understand what lies behind behaviour. This attempt is precisely what modern psychological anthropology seeks to understand (see Cohen, 1994; Spiro, 1997).

Wallace, in his attempts to address the relationship between culture change and individual cognitive models, draws from the work of Barnett (1953), who argues that all innovation must be based on pre-existing mental configurations.

> When circumstances are such that a particular innovative recombination will maximize the organization quantity in a given mazeway, and the physiological milieu is adequate to support the cognitive task, then that innovation will be produced (Wallace, 1961:169).

Therefore, according to both Wallace and Barnett, the new state of the system is essentially a function of the old. To expand on this idea, I argue that individuals, in order to accept, in this case, the new health care policy in Cuba, not only recombine pre-existing mental configurations; but also must be able to locate, within the new policy, elements that are both coherent and cohesive with the meanings attributed to the old system. Therefore, individuals will not likely embrace dramatic change in an institution unless they can find some level of meaning within the new institution that is linked to a pre-existing template. Cognitive maps are not simply reorganized, as suggested by Barnett; but they expand and grow as new meaning is negotiated. This meaning may differ broadly for various individuals; and, as contended by Wallace, the motivations behind the acceptance of the new institution will likely differ from individual to individual.

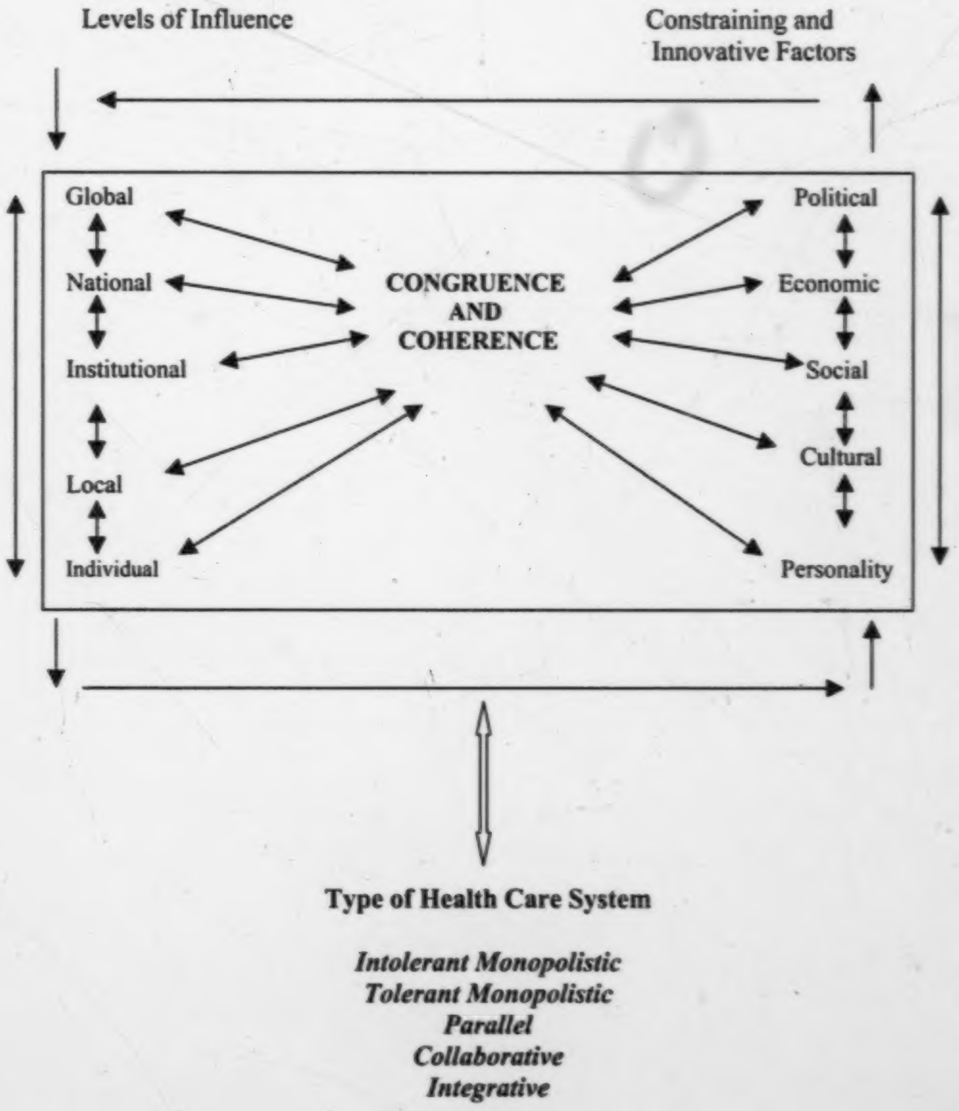
Similarly, Brad Shore (1996:44) describes culture as a set of models. These models take various forms and innumerable shapes that can be either publicly shared or privately held in the mind of an individual. In fact, Shore defines culture as "an extensive and heterogeneous collection of 'models,' models that exist both as public artifacts 'in the world' and as cognitive abstracts 'in the mind' of members of the community." Public models of culture are different from mental models, in that public models are the outward expressions of culture in the form of dance, art, and stories; and may also be expressed through patterns of social interaction such as speech forms, physical gestures, and the practice of reciprocity; whereas mental models are historically patterned and constructed of schemas, socially-transmitted mental structures of knowledge in the minds of people. Although we can develop our own models, many are derived from society (public models). Both kinds of models are influenced by social interaction.

Wallace's model works very effectively in discussing cultural diversity among complex, plural societies such as Cuba. However, when applied to the global network of cultures that are coming into increasing contact with one another, this organization loses its consistency. Many Marxists criticize world systems theory as being too simplistic, due to the general tendency to ignore cultural factors, which ultimately results in the projection of a Western bias for materialism and economic determinism where they do not apply. Therefore it is necessary to combine world systems theory with an acknowledgement of how individual, cognitive models of culture can affect political and economic realities; and how indigenous cultures on the economic periphery may transform or oppose the dominance of the capitalist center (for an example, see Taussig, 1980). If Wallace's model is to shed light on current behaviors and relationships in an age of increasing globalization, it must be modified to include factors that transcend the individual's culture and personality.

A Framework of Health Care Pluralism and Treatment-Seeking Behaviors

Figure 1 provides a framework for an improved understanding of the acceptance, use, and rejection of certain health-related practices. This framework illustrates the constraining and innovative influence of political, economic, social, and cultural factors within each level of interpretation; and how new and old ideas work to establish congruence and coherence at all levels.

Figure 1: A Framework of Form, Function, and Meaning in Pluralistic Health Care Systems



The framework presented here illustrates the complexity of the relationships between all factors and levels of influence. The shape and form of these factors and levels will differ depending on time and place. This framework also demonstrates how the transference of aspects of one system of health care into or alongside another will always look and function differently, again depending on affect and influence of all factors and levels of influence. In other words, it is not possible to impose a system of health care from one context into another, as its relationship to all elements in the framework will result in an altered and often very different form. This is not to say, however, that aspects of a health care system cannot be emulated or used as an example for which other systems can strive toward in the improvement and development of their own systems. In fact, I would argue that there is a lot to learn as well as a lot of relevance to the cross-cultural study of health care systems and practice.

Function and Meaning

I have emphasized here that it is not just individual models of health and illness that predict treatment-seeking behaviors in a pluralistic health care system. Shared cultural understanding of health treatments and illness causation are likewise not good predictors by themselves. What is important is the interaction between local, institutional, and individual models of health that are, at the same time, both constrained and stimulated through political, economic, social, and cultural systems at the national and global level. The dynamic interaction between these levels influences models of health at every point to produce the shape, form, understanding, and behavior we find within the treatment-seeking of any group or individual, at any place or time.

Likewise, the degree of acceptance or rejection of any policy, practice, or system depends on the ability of individuals to find both congruence and coherence. Congruence is present if a practice makes sense to the individual, with only minor cognitive reorganization. It refers to the 'fit' of an event, object, policy, or practice within pre-existing culture or cognitive models. For example, in Cuba the use of herbal medicines within the official health care sector can be said to be congruent with domestic uses of such herbs in the home. Coherence differs in that it refers to the inclusion of new practices, events, policies, or objects within the preexisting cognitive models of an individual or group. The result is the creation of revised cognitive models.

Health care systems vary throughout the world in their content, meaning *materia medica,* symptoms or 'signs' of illness, degree of participation of healer and patient; and the explanatory models of health, illness manifestation, and illness causation of patients, healers, and their families. What does not vary is the requirement that any system of health care delivery, whether it is biomedical or magico-religious, must contain congruent forms of meaning and function for both user and provider. This is not to say, however, that conceptualizations of meaning and function between users and providers are necessarily the same; they often differ, at least to some degree (see Kleinman, 1980).

For example, a biomedical health care provider may arrive in a village in which biomedical understandings of illness and illness causation are not present. The practitioner may present the villagers with the promise that receiving an inoculation will prevent a certain illness. The preventative nature, or the function, of an inoculation may be incompatible with the villager's shared understanding of the nature of the particular illness that the injection is meant to prevent. For example, villagers may believe that the disease is caused by a curse; and preventing that curse may seem improbable (thus, the villagers can find no meaning to the claimed function of the inoculation, and may not believe that the function will occur). In such a situation it is unlikely that consent will be given unless new meanings or functions can be found. The health care provider may be under external pressures to complete his or her vaccination campaign, and may be authorized to provide monetary or other rewards to those villagers who receive the inoculation. The villagers may then perceive a function (receiving money or other goods) in accepting the vaccination, but still see little meaning behind the practice. However, individual villagers may later notice that others who have received the injection do not become ill; and the injection may even be delivered by a local traditional healer whom many individuals trust, and who explains that the vaccine contains a force that can guard against certain curses. In such a case the individual will more likely consent to the injection because it now contains a certain degree of both function (prevention and reward) and meaning that may find congruence and coherence within the explanatory models of disease causation of the villagers. The congruence, in this case, would be found in the traditional healer's explanation of how the inoculation can prevent the effectiveness of a curse and therefore prevent illness, and the coherence would be found in the reorganization of cognitive models of illness causation (the illness still has the same cause, but there is now a means to prevent it from taking hold). Congruence could be made stronger (and thus increase meaning) if the inoculation were to be incorporated into a traditional healing ceremony, thereby increasing coherence.

The above example is simplistic, but it illustrates the need for both function and meaning in the perceived success of any medical treatment. In reality, many cases of treatment may provide an imbalance of function and meaning. In the case in which there is little function to the practice, there must be a high degree of meaning, and vice versa. When there is little meaning associated with a certain practice, there must be a high degree of function. However, in all cases, both must exist to some extent for any medical encounter to be effective. Recent trends in anthropological discourse have served to downplay the value of function in the provision of health care; whereas the health promotion literature tends to downplay the value of meaning, based on the assumption that objective and physical displays of the technologies of scientific biomedical practice will serve as sufficient and practical evidence to any system of meaning. What is important to remember here is that biomedicine and the fruits of its technology are just as much a system of meaning in the West as magico-religious healing traditions are elsewhere.

Likewise, nonwestern belief systems must provide some level of function in order to be accepted by their practitioners and followers. This is especially true within systems of health care. For example, according to Finkler (1991), practitioners of *Espiritualismo* in Mexico deny that any illness is caused by *brujeria* despite the initial claims of many patients. By denying any source within the direct realm of the patient's social existence, the healing practices of the *Espiritualista* can therefore serve the function of improving social relations for the patient (Finkler, 1991). Furthermore, the *espiritualistas* in Mexico discourage behaviors that are perceived as disruptive to the home life of the patient, which further promotes peaceful social relations for the patient (Finkler, 1981).

According to Lewis (1993: 213), "you can go on believing many things without actually having to put them to the test but that is not always the case with medical treatment." It is important to point out that there are a variety of methods for measuring and conceptualizing efficacy, but many fall outside the narrow scope and recognition of biomedical science (Waldram, 2000). While evidence of 'truth' is crucial, truth is a socio-cultural (Berger and Luckmann, 1966; Young, 1993) and individual variable, rather than a universal. Therefore, if a particular health care practice repeatedly fails to serve its ultimate function of improving the state of individual or group health, in whatever form it is perceived, it is unlikely that such a practice will continue in its existing form. If it were to do so, the level of meaning would have to compensate to such an extent that the meaning in itself would serve as function.

According to the framework in Figure 1, all levels of influence and all constraining and innovative factors must find some level of congruence and coherence as they are exchanged. Furthermore, the new forms created through the congruence and coherence of exchanged variables will in turn influence the creation of new variables. All new and existing variables are constantly undergoing renegotiation and reshaping as their function and meaning is translated at every level, influenced by a variety of factors.

Levels of Influence

The very process of globalization itself has changed the core-periphery relationship, as the new core is now a multi-centered political economy. Hannerz (1992a) argues that the organization of diversity can, in fact, be applied to the new global ecumene. However, since the only currently existing institutions delineating international laws are the various branches of the United Nations which have been shown to reflect Western, capitalist ideals (see Simons, 1994), the organization in Wallace's organization of diversity model breaks down; or at the very least, becomes hegemonic in defining its boundaries. This situation is evidenced in numerous studies of the localization of the United Nations Declaration of Human Rights (UNDHR) and the WHO's advocated methods for reaching 'health for all by the year 2000.' Wendy James (1995) adds another dimension to this complex interaction by arguing that in this age of rapid information exchange (i.e., the Internet), the individual can dialogue and interact directly at the international level, bypassing the filtering or mediating actions at the level of the nation-state. However, as Hannerz (1996) points out, any analysis of the effects of rapid information exchange must take into account the uneven levels of accessibility to these sources of information.

The structural power accorded to the biomedical paradigm operates internationally, and therefore influences policy in a way that cultural sensitivity is often ignored or forgotten. Thus, biomedicine, as it is promoted at the international level, often acts as a neo-colonial force, taking those aspects of traditional medicine that suit its paradigm while ignoring all others. As pointed out by Pederson and Barufatti (1989), while traditional medicine tends to overestimate its effectiveness, it is also able to acknowledge that biomedicine is superior in the treatment of certain diseases and symptoms; in contrast, the general trend in biomedicine is to treat traditional medicine as though it is mostly superstition and charlatanism, containing little or no medical knowledge.

The World Health Organization has recently stated that

> A genuine interest in various traditional practices now

> exists among practitioners of modern medicine and growing numbers of practitioners of traditional, indigenous or alternative systems are beginning to accept and use some of the modern technology. This will help foster teamwork among all categories of health workers within the framework of primary health care. The reasons for the inclusion of traditional healers in primary health care are manifold: the healers know the socio-cultural background of the people; they are highly respected and experienced in their work; economic considerations; the distances to be covered in some countries; the strength of traditional beliefs; the shortage of health professionals, particularly in rural areas; to name just a few (WHO, 1996).

In advocating for health care pluralism, the WHO fails to incorporate the actual 'system'; instead, the *materia medica* is seen as providing a cheap alternative to unavailable biomedical drugs, and traditional practitioners are seen as vehicles for the distribution of biomedically-conceived health promotion programs. The move toward traditional medicine has largely occurred on a popular and policy level, while biomedicine continues to resist its penetration, except in those areas that prove useful to its own model. Ultimately the 'teamwork' promoted by WHO only occurs when biomedical practitioners and policies are the 'team leaders.' This interpretation is supported by Odebiyi (1990), who surveyed western-trained nurses in Nigeria; and found that they were in favour of collaboration with traditional healers only if biomedicine ultimately remained in control of the decision-making process.

The current state of Cuba's official health care system is a perfect example of how biomedical systems utilize aspects of alternative and traditional systems in order to fill areas in which biomedicine is deficient, thus allowing biomedicine to remain hegemonic in clinical practice. Cuba is, like any other nation, a part of a global system, influenced, interacting, and participating in contemporary political, economic, and social realities. Chapter four has demonstrated how the Cuban government is making use of current global networks and influence to reshape their medical ideology in a way that maintains Cuba's commitment to socialized medicine and scientific principles while also retaining its international reputation as a leader in health care delivery. This goal is accomplished through a remodeling of biomedical practice that allows aspects of alternative and traditional medical systems to fill gaps left from a lack of access to biomedical pharmaceuticals and equipment. This approach is justified by maintaining that the Cuban health care system is following international trends in health care delivery laid out by international organizations such as the WHO, and in the sharing of such health-related information through exchanges of health-related knowledge with other countries in the spirit of 'solidarity.'

Within the level of the institution, further constraints on the participation of alternative healing traditions may be found. For example, within academia, the current postmodern trend of thought and theory, while serving to reveal the power imbalances and structural constraints inherent in global-national-local relations, argues that cross-cultural comparison and application is not possible, due to extreme differences in the starting points of 'western' versus 'local' knowledge systems. As a result, 'nonwestern' thought and theory are left out of the decision-making process; and nonwestern theories and worldviews are dismissed as 'local', and having little relevance outside of their immediate sphere of existence. Moore (1996:6) argues that, far from the postmodern claim that cross-cultural comparisons of knowledge and theory are of little actual value, it is important that anthropology recognize that local knowledge, including local technical knowledge, can be part of a set of 'knowledges' properly pertaining to political economy and the social sciences; and anthropology thus be comparative in scope as well as international in outlook. One alternative approach is to utilize cross-cultural comparisons, and assess value in dealing with various global issues and problems. In doing so, we must avoid using western society as the starting point of any comparative and generalizing theory. Anthropology is most certainly the best discipline for making this change by taking seriously other conceptions, cultures, and worldviews (see Moore, 1996; Karim, 1996; Hannerz, 1996). In terms of systems of health care, Mathews (1998:341) claims our challenge should be

> to document locally variant forms of reasoning and to build a broader comparative theory that accounts for similarities and differences in their content, use and application while also attending to the processes individuals use to frame and interpret creatively their own illness experiences.

Long (1996) and Hannerz (1996) argue that globalization, far from contributing to the worldwide homogeneity of culture, has in fact created an increase in diversity. This increase in diversity is due to the diversified patterns of responses to the process of globalization at local, regional, and national levels (Long, 1996); and the ability of the periphery actively to manipulate meanings from the core, and incorporate these transformed meanings into local cultural life (Hannerz, 1996). Some researchers believe that through globalization, increased attention can be given to traditional health care systems; and that efforts will be made to preserve or revitalize their practice (Hyna and Ramesh 1994; Tamil Nadu, 1994). Hudelson (1993) has shown that even multinational pharmaceutical companies that are attempting to expand their markets in the developing world, with heavy marketing campaigns aimed at 'modernizing' impoverished countries, have affected health care practices and cultural beliefs; but not in ways previously expected. The result, she claims, has been a pervasive cultural pluralism that is neither leading to a disappearance of traditional, indigenous explanatory models, nor a widespread understanding of biomedical explanations of disease causation and therapies; instead, these elements are intermingled. The data that I collected in the clinics in Alonjas and from Cuban patients who have utilized the services within the unofficial and official sectors support Long (1996) and Hannerz' (1996) notion that globalization, rather than leading to increased homogenization, has in fact led to an increased diversity in the doctor-patient encounter in Cuba. Likewise, evidence can be found for Hudelson's (1993) claim that globalization has affected the health care system in a way that produced new and innovative forms of understanding illness causation and treatment.

The effects of globalization have led to a situation within Cuba whereby less biomedical drugs are available to patients. As a result, patients in Cuba today have increased access to a variety of health care systems both within and outside of the official health care sector; that is, when visiting a doctor within the official system, patients are exposed to a variety of treatment options including acupuncture, homeopathy, massage, moxibustion, herbal remedies, hypnosis, and mud therapies. These treatments are offered as an inexpensive alternative to the expensive biomedical drugs that Cuba can no longer afford to provide, or does not have access to purchase due to increasingly strict trade embargos to the island. Furthermore, the incorporation of such treatment options within the official sector has indirectly resulted in an increased tolerance of the treatment options available within the unofficial sector.

The options available within the unofficial sector have always existed in Cuba, but through the process of globalization they have become more accessible and arguably more desirable. As described in Chapters five and six, individual Cuban patients continue to assess their illnesses and available treatment options based on their experiences with all forms of treatment. Furthermore, their experiences within the health care sector are contextualized and understood in relation to a variety of individual life experiences and the processes of socialization and enculturation as described in Chapter six. Alternative treatments within the official sector have not affected the philosophy whereby treatment is delivered to any significant extent; e.g., acupuncture is still delivered according to a biomedical framework of disease and illness causation rather than within the philosophical context that it has traditionally evolved. Therefore, alternative treatments within the unofficial sector remain popular.

The category of the individual and the self are of paramount importance in any discussion about health care provision. Grace Harris (1989) has clearly defined the separation between the concepts of self, individual, and person. The individual, she maintains, is a biological category, a human unit. This human unit, however, is not always confined to the body, as evidenced by such examples as werewolves in Europe and shape-shifting magicians from Africa, whose individual bodies can be altered. The person is a social category, and refers to the position one holds within society. Persons, however, still maintain a certain degree of autonomy in the sense that persons are held accountable for their actions. The self, however, is a psychological category in which the human being is viewed as the locus of experience. What counts as sickness depends on the perceptions and the experiences of the patient. This definition is individual (e.g., an athlete's health will be different from a paraplegic's health), cultural (depends in part on culturally-prescribed perceptions of what a 'self' and thus a 'whole self' is), and experiential (how the self experiences its own health and illness) (Hahn, 1995). For example, the philosophy behind the biomedical approach to health and illness is one that generally views the physical and psychological aspects of the individual as separately existing entities. Within the context of a 'western' society, governed by the doctrine of the scientific method, such a medical philosophy is both congruent and coherent with preexisting cultural values (although not always with the values held by individual selves). In societies in which the distinction between self and other is not as clearly defined, and where biomedicine is practiced, biomedicine has taken new and distinct forms, as there must be a link to preexisting cognitive models of health, healing, and illness. In Cuba, for example, while biomedicine was wholeheartedly embraced at the time of the revolution, it took an altered form that took into account Cuban-shared cultural ideals concerning the health of individual selves and communities. The patient in Cuba is an integral part of society, part of a family and part of a nation. The separation of the individual person from these relationships is not as easy to reconcile as it is in the 'western world.' Reflection of this attitude can be seen in treatment-seeking behaviors that aim to address the problems that have arisen in the current socio-economic climate of contemporary Cuba.

An individual's sense of self, that is, lived experience as an interaction with the surrounding physical and social world, may have predictive value in anticipating the form of treatments sought by individuals within a given society. The success of any system of health care delivery will depend on its ability to be both coherent and congruent with individual concepts of self (Harris, 1989). Hollan (1992) argues that anthropologists, when studying variations in the self cross-culturally, must ask themselves if they are referring to a different culture's ways of talking about the self, and therefore actually speaking about the construction of self; or if they are referring to variation in aspects of subjective experience. Hollan contends that talking about the self will always serve to 'construct' the concept of self. However, the self is not just a cultural construction, as the subjective experience of the self is important. Hollan concludes that while anthropologists have successfully shown that concepts of the self may vary from one culture to the next, they have not sufficiently examined how those concepts relate to the experience of the individual; and that the task now is to investigate both the manner and the extent to which these various models are actually 'lived by,' and thereby to ascertain the range of the experiential self as well (1992:295).

Likewise, each type of health care system has a different perception of what an 'absence of wholeness' within a 'self' entails; therefore treatment must address this perceived absence of wholeness within the context of a particular health care system's understanding of 'self'. There is a dynamic relationship between the underlying ideals of the health care system and the underlying ideals of locally-shared culture. The individual self derives meaning from this interaction, as it fits into its world of experience. Perhaps the ready acceptance of alternative and traditional health care systems in Cuba is due to the fact that associated notions of 'self' are more congruent (than those of biomedicine) with both Cuban cultural and individual ideals of the self. This hypothesis may also partially explain the reluctance to accept certain forms of alternative and traditional health care in Canada, especially by those of European ancestry or cultural background, because of 'western' cultural ideals pertaining to the separation of the mind/body, and the heavy value placed in Euro-American society on individualism and independence (see Dumont, 1986). It is therefore logical to argue that our ideas of health and how health can be maintained cannot change without an accompanying modification in our definition of what it is to be a 'self'. However, this modification is constantly being done as the boundaries of self are expanded with each and every new connection. In Cuba, individuals are currently being challenged to deal with a new socio-economic and political reality that has created new and diverse problems that either directly or indirectly affect their state of health. This situation means that treatment-seeking behaviours will tend toward addressing the new problems that affect health in one way or another.

However, such models of 'self' and the accompanying models of 'health' and 'illness' are not cognitive isolates, immune from the effects of events in the outer world of experience. Instead economics, politics, and culture at the local, institutional, national, and international levels interact with individual models of health and illness.

Constraining and Innovative Factors

Critical medical anthropology has made a substantial contribution in addressing the constraints that political and economic power relations exercise on health care. Singer (1996) argues that critical medical anthropology brings to light the essentially eugenic ideology perpetuated in the bio-cultural model of medical anthropology. Influenced by Marxist theory and dependency theory, critical medical anthropology analyses the impact of global economic systems, particularly capitalism, on local and national health. Political anthropologists, such as Merrill Singer and Hans Baer (1995), argue that change programs should not be attempted unless one also studies the social production of illness and poverty within the larger dynamics of class interactions, colonialism, and world economic systems. This analysis provides the contextualization necessary to understand the changes current in Cuba's health care system.

Globalization, as an economic process, has an accompanying political philosophy, that of neoliberalism. Essentially neoliberal political theory argues that the market is the most efficient mechanism for the distribution of goods and services in any society; and accordingly, a capitalist economy is the best way to produce such goods. Neoliberals argue that increasing access to international markets and resources will inevitably improve the lives of all involved, usually through the 'trickle-down' effect (Oxham, 1998). Neoliberalism, however, is often inconsistent with the belief patterns and survival strategies of many nonwestern countries. This can be seen in the current state of many Latin American countries, where the structural adjustment process of the eighties has increased the percentage of the overall population living in poverty to 45%. Income distribution has also worsened, and the GDP in many Latin American countries has decreased (Loker, 1999). However, some argue that the effects of globalization have not only been negative. Some communities have proven quite adaptable, at the level of local institutions, to target new or changing markets. For example, Orlove (1999) provides examples of the reinforcement of local institutions in the face of globalization.

The idea that having the economic resources to purchase expensive biomedical equipment and pharmaceutical drugs, and health care indicators are intimately intertwined is common within the health promotion literature (e.g., Shimkin, 1996). While it is true that people with a lower socioeconomic status are more prone to certain types of illness, these are usually illnesses that are best dealt with using simple low-technology strategies such as prevention, or the improvement of environmental and social factors (Laurell, 1989). Despite this, many health promotion projects continue to argue for the provision of complex, specialized, and expensive technologies, often in communities in which such items are inappropriate for dealing with their particular health issues. Promotion of expensive pharmaceuticals, hospital construction, surgical and diagnostic equipment, and numerous ancillary goods and services benefit large corporations who form allies with third-world elites and influence policy (Baer et al., 1997). The result can lead to decreased self-sufficiency, and increased dependence on availability and accessibility (see Lewis, 1993). A further problem is that many nations have weak tax systems, inflexible expenditures, and enormous foreign debt that reduces health budgets. For example, the economic crisis in the 1980s caused health care expenditures in the Latin American countries of Bolivia, Guatemala, Dominican Republic, and Surinam to drop because of the sharp increase in interest on external debt (Curto de Casas, 1994). As a result, international 'aid' projects often deliver inappropriate technologies; and do little to make real change in the health status of individual persons. However, the very dependency of biomedical health care on imported drugs and technology has resulted in perpetual rises in the cost of treatment, and a corresponding shortage of materials. As a result, there is growing opinion that biomedicine is too expensive; and that the quality of health care it provides is deteriorating. This situation has resulted in a renewed interest and resurgence of traditional and alternative systems of health care.

Even in Western European countries, the development of pharmaceutical drugs to treat illness such as tuberculosis, whooping cough, and scarlet fever has not played the most important role in eradicating such illnesses. In mid-nineteenth century England and Wales, tuberculosis was the leading cause of death. Sanders (1985) has shown that the introduction of the streptomycin drug cure in 1947 and the BCG vaccination in 1954 did not seem to have had a dramatic effect on the number of deaths from this disease. Instead, it appears that these illnesses were decreasing at a steady rate before the introduction of these pharmaceuticals, due to increased access to clean water and proper sanitation. By the time of the introduction of the drugs, mortality from TB had already fallen to a small fraction of its level in 1848-54. While drug treatment is responsible for the more rapid fall since 1950, the most substantial reduction occurred before the introduction of antibiotics and vaccines. Likewise, the number of deaths due to diphtheria, scarlet fever, whooping cough, and measles had fallen to almost their present levels due to improved food hygiene, disposal of sewage, and access to food before the introduction of antibiotics and compulsory immunization in the 1940s in Europe (Sanders, 1985:33). In fact, according to Sanders (1985:36), since the early 1800s, the huge fall in illness and death resulted from the following, in order of importance:

A. Improved living standards
B. Improved hygiene
C. Specific preventative measures (e.g., smallpox vaccination)
D. Much later, curative measures (e.g., antibacterial drugs)

Baer et al., (1997:5) emphasize the importance of political and economic forces, including the exercise of power, in shaping health, disease, illness experience, and health care. More recently, critical medical anthropology has begun to address ecological factors in health, viewing 'nature' and 'adaptation' as cultural constructions reflective of a social and political order; and not simply biological givens. Baer and Singer argue that a critical perspective seeks to identify connections between several levels of analysis such as the 'macro- social,' 'intermediate-social,' 'micro-social,' and 'individual.' As such, the availability of economic resources alone does not predict the state of a nation's health indicators. For example, many countries with high GNPs (e.g., Saudia Arabia and Libya) also have low overall life expectancy, whereas many countries with a low GNP (e.g., Costa Rica, Cuba, Vietnam, and China) have high overall life expectancy (Caldwell 1993). Furthermore, an internationally recognized successful biomedical system is not dependent on high costs. If we consider that Cuba has a total GNP of 13.7 billion USD (UNICEF, 1996) and Ontario alone spent 9 billion in health care for its 8 million inhabitants in 1988 (Sutherland and Fulton, 1992), the lack of correlation between cost and type of health care provided widens even further.

There are many studies that indicate that the social factors that contribute to health may be more directly linked to the actual health profile of a country (Laurell, 1989). For example, Caldwell (1993) has shown that in South India, the educational level of women is a very important indicator of the state of children's health. Caldwell argues that more highly educated women are likely to have fewer children (allowing them to invest more time and care into each child), are more aware of preventative practices, are more likely to argue with their husbands and mother-in-laws for treatment of their children when they are sick, interact more competently with modern health care services, and are more likely to follow medical instructions. A study by MacCormack (1988) produced similar findings, indicating that the relationship between a woman's social status and educational level is directly tied to the survival of her children.

Kleinman (1995) argues that the idea that objectivity underwrites practical applications is linked to the idea of progress. The demographic transition is used to measure the progress of health in a given society, as objective measures are needed to influence government policy-makers to allocate resources, despite the fact that this is an arbitrary distinction. Therefore, the success of new policy implementation must not be measured according to international health indices (i.e., the number of hospital beds/doctors per capita). This strategy does not address the role of preventative treatments in traditional medical systems, and consequently directs the investment to curative healing. Since there is no end to the demand in resources for the treatment of illnesses, little room is left for health promotion and prevention. This situation further reinforces the dominance of high-tech diagnostic procedures and hospital-based surgical and pharmaceutical treatments that focus on intrusive biomedical practices, and exclude holistic approaches to health which are more appropriate in most countries (Kleinman, 1995). Rather, more culturally relevant and specific indicators (i.e., the quality of health) should be used in determining levels of health care provision.

There has recently been much criticism of cross-national studies of welfare that evaluate social welfare in terms of one determining factor, namely per capita income, as in the social welfare comparisons provided by the Physical Quality of Life Index (PQLI). As a result of this controversy, Gough and Thomas (1994) have developed a comprehensive model of national difference in need satisfaction to replace the PQLI. The authors conclude that per capita income is only one of several factors explaining cross-national variations in need satisfaction; and argue that the degree of economic and political independence, the extent of democracy and human rights, the capacity and dispositions of the state, and relative gender equality all positively and independently affect a nation's level of welfare. It has therefore been recognized that economic development alone cannot guarantee social development. This conclusion has further led to a greater degree of leniency in determining the level of success attributed to biomedical health care systems at the local level.

Ajquejay's (1993) fieldwork with the Kaqchikel in Guatemala confirms Gough and Thomas' (1994) conclusion. He argues that within developing countries, the redistribution of land is seen as essential to the provision of health. He maintains that the success of Carroll Behrhorst's work in Guatemala came from his realization that simply curing the sick was pointless, since that did nothing to change the overall state of health; so he employed preventative measures which included both economic and social transformation. For example, land was purchased and distributed among the Guatemalan people he studied; likewise employment was provided for people in areas of education and nutrition. These measures served to get community members directly involved in their own preventative health care. Ajquejay concludes that previous attempts to provide effective health care have failed in Guatemala and elsewhere because there was no active participation of the people in their health care programs.

Typologies

In the study of any pluralistic health care system, a researcher must be able to identify the form of that system, and the factors and conditions that contribute to it. If the 'type(s)' of pluralistic health care system can be identified, the treatment options for individuals within a given community may also be identified.

All of the factors in the top half of the framework in Figure I influence a functioning health care system. The resulting shape and form of the health care system, in turn, affects the relationship between the various levels of influence – the constraining and innovating factors. For example, if an individual doctor believes that the use of alternative therapies in the hospital is a sign of a deteriorating system, this attitude will affect his or her interaction with both the institution of health care and with his or her patients. As a result, the patient may experience a loss of respect for doctors and other medical staff; and a decrease in trust in the ability of the health care system to provide adequate health services. This in turn may have a social effect, in that the individual may perceive the changes in health care services as a sign of a failing society; and, due to this perception, experience a decreased motivation to work. This, in turn, can affect productivity in the workplace.

The typologies presented in the bottom half of the framework, entitled, "types of health care systems," are based on the relationship and interaction between traditional or alternative health care systems and biomedicine. What is important in this relationship is not just the relative power accorded to each system; but also the accessibility, cost, and extent of coverage for each system. Such 'types' are ideological in nature, with very little possibility that any would ever exist in their 'true' form. Moreover, I have discovered through my research that the health care system within any community is not easily classified, since it may include more than one of the above 'types.' For example, in Cuba there exists both an attempt at an integrated system (in the official health care sector) as well as a system that falls somewhere between that of an intolerant monopolistic and a tolerant monopolistic system. Therefore, these 'types' have to be viewed in the context of the framework as a whole.

Chapter 8: Conclusions: Toward a Universal Framework of Health-Care Pluralism Based on the Cuban Example

Throughout the chapters in this thesis, I have developed an image of pluralistic health care in Cuba as I saw it. In Chapter one I provided a historical and cultural background of Cuba, emphasizing the social-political context from which contemporary Cuban society has arisen. Chapter two described the methodology that I employed throughout my data collection, and the theoretical basis for my analysis of that data. Chapter three examined how the international and national dialogues create and implement boundaries within which health care is to be officially practiced. Chapter four described the current state of Cuba's health care system and health care policy, and how the changes in policy and practice continue to serve to maintain the political ideologies of the Cuban government. Chapters five and six address local and individual experiences with health care; and illustrate how explanatory models of illness direct and influence treatment-seeking within both the official and unofficial systems. In Chapter seven, I have developed a framework of form, function, and meaning in pluralistic health care. I will now provide several examples from my own research to illustrate how levels of influence and constraining and innovative factors interact in a dynamic fashion to produce new and changing experiences and suggest possible future directions, including the role of medical anthropology in the study of pluralistic health care systems.

International, National, and Political Relations:

Since January first, 1959, Cuba probably more than any other country has been under the watchful eye of the international community. Some view Cuba with awe and respect, others with pity, and still others with vengeance. In either case, for Cuba, the opinions of the international community are of paramount importance. The lip service provided by the WHO to the utilization of alternative and traditional forms of health care has provided the Cuban government with the much needed justification for what may otherwise be perceived as a step backward in the island's development of medical technology and science. MINSAP officials in Cuba will often quote WHO policies and definitions; and maintain that using traditional and alternative medicine is a 'global trend,' and not just a response to economic crisis. This position serves Cuba well in a time when international scrutiny is increasing, and the socio-political fabric of the country has begun to unwind.

Cuba began the process of implementing traditional and alternative medical practices by inviting medical practitioners from other countries to share their knowledge and techniques with Cuban Ministry of Health officials and doctors. The current system is seen as the result of ongoing mutual cooperation with other national governments and the international community.

Economic Innovation and Constraint:

The current economic situation in Cuba both constrains and introduces innovations into medical practice in a manner very different from other nations. In Cuba medicine is practiced at the local level; it is a social service and not an economic endeavor. In North America, and especially the United States, biomedicine is a big business that generates large amounts of income (e.g., insurance, pharmaceuticals, advertising, technology and equipment, litigation, etc…). The economic aspect of medicine creates unique situations for the practice of traditional and alternative medicine in both Cuba and North America. In North America, the American Medical Association and the Canadian Medical Association see alternative medical practices and their pharmaceutical products as an economic threat. Alternative practitioners and proponents of alternative medical practices must compete with those stakeholders in pharmaceutical and other medical industries, who hold far more political and economic resources. In the end, intensive energy is expended on trying to debunk each other; or claiming efficacy in their own system beyond their capabilities. In contrast, in Cuba, alternative medical practices have the support of the state; and therefore do not face such opposition. When the economic aspect of medical practice is removed, there is far less pressure for those working in the medical profession to adhere to the demands of those trying to promote certain products (i.e., drugs and equipment). As one MINSAP official put it:

> One great advantage of our system is that we don't have the transnational companies like you have; we are not in the business of medicine; we are not trying to sell anything to the Cuban people; and so with health care we are lucky in that we don't have that problem with medicine and money.

Cuba has made changes to its official policy, as a result of the lack of available resources, in an attempt to maintain the system it had prior to the Special Period. While many government officials maintain that Cuba was already heading in the direction of utilizing many of these alternative therapies, there is no doubt that the current economic crisis was the catalyst that produced such practices within the official health care system.

Institutional, Local, and Individual Interpretations of National Policy:

Official policy indicates that all herbal medicines to be used within the official system must pass through a number of rigorous tests that employ biomedical understandings of treatment and cure. However, as evidenced by the data presented in Chapter five, individual doctors and patients deliver and accept the 'new' treatments with varying degrees of acceptance and rejection. In the clinical encounter, the shape and form of *la medicina tradicional y natural* is a constantly shifting manifestation, resulting from the dialogue between doctor and patient and often even the patient's family.

Institutional Innovation and Constraint:

Cuba's official system is an attempt to integrate aspects of alternative and traditional health care systems into the existing system. The foundation and reasoning of biomedical science has not been sacrificed to the health care reforms; rather, new therapies are often reshaped to suit the pre-existing system.

Institutional and Individual Cohesion:

The facts that the new health care policy in Cuba is drawing partly on the traditional knowledge and practices within Cuban communities, and the changes have not altered the overall structure of the health care system, provides cohesion between the pre-revolutionary, revolutionary, and 'special period' health delivery models. Furthermore, the fact that the pre-special period health care system was already very much a community-based system, and the fact that the philosophies of most traditional and alternative health care models incorporate many of the ideals of Cuban culture, provides the congruence necessary for the successful adoption of this new policy. Furthermore, despite the relatively straightforward boundaries outlined in the official policies, the interpretation and practice of medicine and various therapeutics, upon closer examination, are in fact interpreted and employed in a wide-ranging multitude of forms by both doctors and patients, providing even more diversity within the organization.

International, National, Social, and Cultural Coherence:

Cubans, in general, accept the changes to their official health care system because they view the changes as another *vamos a resolvar*. Medical ambivalence on the part of Cuban patients allows them to accept new and alternative forms of health care so long as they are perceived as working. Cuba's state government informs the Cuban people of the relative advantages of using less intrusive and more cost-effective medical treatments, and emphasizes their worldwide acceptance. Evidence of this advantage and acceptance is provided through educational campaigns, and international congresses with alternative medical practitioners from other countries. Furthermore, while there is a fascination and respect for science at the national and institutional level, many Cubans maintain that their roots are rural in origin; and they therefore appreciate the ability of nature to treat illness over high-tech invasive treatments.

National, Institutional, and Personality Congruence:

The example of Blanca provided in Chapter five seems to indicate that the boundaries set at the national level will be shaped at the level of the institution, depending on the personality of those trusted to implement them. Blanca, while a well-respected MINSAP official, feels a personal affiliation toward the practice of traditional Chinese medicine. Blanca wants to see TCM practiced within the context of its philosophical grounding. She interprets 'scientific evidence' quite broadly (e.g., "the Chinese have been using it for thousands of years"), in order to provide the congruence necessary to stretch the boundaries of official policy for her own practice.

National, Individual, Personality, and Social Innovation and Constraint:

The experience of the patient in the doctor's office is the process of a social negotiation between doctor and patient. For example, Blanca's personality allows her to interpret national policy and apply this interpretation to her practice, as she believes it should be done. In turn, the patient may perceive Blanca's enthusiasm as an indicator of medical efficacy. On the other hand, Hugo does not believe in the efficacy of the recently-introduced alternative treatments. Hugo's disdain for, as well as his refusal to use alternative therapies, would likely result in his presenting a negative picture for his patients; and therefore cause them to question the efficacy of the alternative treatments within the official health care system. In any case, the patient's experience in the doctor's office, as well as any past experiences with traditional or alternative practitioners, is constantly being evaluated in light of each new illness episode and treatment experience. Treatment-seeking behaviours are therefore not mechanical responses to an illness episode; rather, they are based on the experiential and historical knowledge of the individual patient.

Internal explanatory models are linked to the outer social world, and expressed symbolically through the illness experience and the interpretation of its cause. For example, the belief that breast cancer is caused from beatings reflects women's resistance to gender domination (Hunt, 1998); and, as may be the case in Cuba, the belief that unseen forces can be manipulated to cause illness can be seen as reflecting resistance to social control and domination. Likewise the type of illness experienced by the individual is influenced by social interaction within and outside of the medical encounter.

Economic and Social Innovation and Constraint:

Life in contemporary Cuban society is difficult. The economic crisis of the special period has resulted in inadequate salaries, housing, and transportation, as well as shortages in basic necessities that have resulted in high levels of stress and stress-related illnesses. Due to the more personalized nature of stress-related illnesses, they are generally seen as being more effectively treated in the unofficial sector, or at least through alternative therapies within the official sector.

The International, Individual, and Economic Constraints and Innovations:

Likewise, economic constraints that have resulted in shortages have had detrimental effects for some individuals who require medical treatment that the health care reforms have not been able to replace. One common example is that of diabetes. One diabetic patient at the clinic said

> All my medicine, I have to ask my friends on the outside for my medicine, diabetic medicine. Because this is what has happened to us. The medicine here is very good medicine; yes, we are very good with medicine and everything but the medicine for diabetes came from just one company; and I have always been a diabetic, and I lost most of my eyes from this disease; and so now I have to look for my medicine from the outside; and it is very difficult, you know, because you don't earn in dollars, you earn in *pesos cubanos.*

This person has been forced to rely on external sources to receive her much-needed medications. This situation has had a negative effect on her state of health, as her access to such medications remains dependent on the generosity of foreigners.

The Current Form of Medical Pluralism in Cuba

Initially I believed that I was going to Cuba to study a collaborative health care system; an 'ideal' system by the world's standards - a system in which practitioners of traditional and alternative medicine cooperate with biomedical practitioners, each working from the ideological base from which their own system originated. What I found was quite different; and, while far from ideal, Cuba's health care system remains structurally sound. Despite severe economic circumstances, Cuba's health care system has been responding in creative and innovative ways to continue to provide its population with free, accessible, and effective health care.

Cuba's official health care system is an attempt at integration in that alternative and traditional therapies and *materia medica* have been incorporated into the dominant biomedical system. While this has been done largely to fill the gaps left by an economically-deprived biomedical system, it has not been without philosophical and ideological repercussions. As presented in Chapter four, the knowledge of diverse medical traditions imported from other countries such as China and Vietnam has led to a great deal of interest on the part of many individual patients and doctors in the philosophical groundings of such systems. There are state-funded institutes that study the relationship between Chinese philosophy, language, and health care; and there are well-respected government officials who openly state that they believe the holistic doctrines of traditional Chinese medicine have a more positive effect on the health of patients. At the same time, few denied or rejected the benefits of biomedicine for certain purposes; and only one individual believed that an alternate medical system should fully replace biomedical practice. Likewise, the curriculum in Cuban medical schools teaches many aspects of traditional Chinese medicine, as well as biomedicine. For example, physiology classes, in addition to teaching about bones, muscles, and the nervous system, currently teach the location and nature of meridians, acupuncture points, and sometimes even the chakras.

In Cuba there are several rich and diverse healing traditions that exist separate from the officially recognized system of health care delivery. Due to this reality, it is misleading to classify Cuba's health care system simply as an attempt at integration. While these practices are recognized, practiced, and valued by many individuals, both patients and medical professionals, unofficial practices do not have access to state resources; and their value (existing, perceived, or potential), aside from the chemical properties of popular home remedies, is not addressed or accounted for in any official health care policy. In fact, while there are no state sanctions against unofficial healers, the extent to which they actually exist and practice in Cuba is often denied, downplayed, or ridiculed by many government officials. However, changes currently being made within the official health care system have led to an increased tolerance toward the unofficial health care system by high-level government officials. In this case, the Cuban health care system can be generally classified as shifting from intolerant monopolistic to tolerant monopolistic. However, within the clinics and hospitals many doctors treat their patients with a variety of therapies, what may be termed an integrated system. Likewise, there are individual doctors who employ health care practices from the philosophical base from which they evolved, separate from their biomedical practice (e.g., Lazaro); and therefore resemble a more collaborative system of health care delivery. Ultimately, the personality of the practitioner greatly impacts on the form and shape of practice.

Many Cubans report an increase in stress-related illnesses; and perceive the cause to be of a socio-economic origin that affects not only their immediate person, but also their families and their communities. It can therefore be argued that regardless of which typological category into which the contemporary Cuban health care system falls, it is both obvious and apparent that all changes in health care delivery, whether they be in the official or the unofficial sector, are greatly affected, directed, and negotiated within the larger political and socio-economic conditions that exist within contemporary Cuba. These conditions, in turn, are played out within the lived everyday realities of all Cubans - doctor, patient, or politician.

The Role of Medical Anthropology in the Study of Pluralistic Health Care Systems

Medical pluralism has been well documented and frequently discussed in the Latin American literature (see for example, Crandon-Malamud, 1997; Finkler, 1991). In fact, health care pluralism exists to some extent in every part of the world. Even with the increasing spread and marketing of biomedical medicine, there has been little evidence of a reduction in traditional beliefs and healing practices (Pelto and Pelto 1997). Instead, practitioners of alternative or traditional health systems often incorporate and reshape certain aspects of biomedical practice; likewise, biomedical practitioners draw on or reject traditional and alternative health care practices to varying degrees (Pearce, 1993; Pederson and Barufatti, 1989).

Despite biomedicine's long history of debunking medical practices and beliefs not seen as being compatible with its own model (see Walker, 1994), it is now obvious that the western scientific paradigm is currently undergoing a paradigm shift, since it is increasingly being forced to address alternative health systems as they exist at every periphery of biomedicine. Biomedicine is therefore no longer in a position to devalue or debunk these alternative ways of healing. In fact, Bodekar (1994) has documented the changes in attitude on the part of western biomedicine toward traditional health care systems; and has found that perceptions of traditional medicine have shifted from being perceived as primitive, ineffective, marginalized, becoming extinct, needing to be regulated, a source of leads for the pharmaceutical industry, and an active ingredient model, to holistic, cost-effective, locally available, undergoing renewal, needing to be promoted, valued in its own right, with local economic value, and having synergistic energy. This is a positive finding in that it demonstrates that the paradigm shift within western biomedicine has already begun, leaving hope for future collaboration.

In any multicultural society, there is a definite need for health care policy that can address the diverse explanatory models of illness and disease causation present within the population. The literature has pointed out several problems in the delivery of health care when two or more different explanatory models of illness and illness causation are present within the clinical encounter. For example, Morse et al. (1991) have shown, through a comparison of the Cree methods of treating disease and the treatment process and procedures used in western biomedicine, that there are several incongruities that the Cree may encounter when using the western system. They conclude that native people in Canada are frequently dissatisfied with the western system; in particular, with the passive rather than participatory role they are expected to play within the clinical encounter, preventative treatment and silent diseases, and the limited perspective of holism in western biomedicine. Frideres (1988) points out the lack of understanding on the part of Canadian medical professionals in dealing with native culture and culture-bound syndromes that often result in several symptoms going unrecognized. O'Neil (1986) addresses the problems that occur when primary health care services exclude their Canadian Inuit clients from meaningful involvement in health care planning.

However, studies have been done to suggest methods by which the dominant medical system can better address the needs of its multicultural clientele. Dunn (1987) emphasizes the importance of educating medical professionals about differing concepts of time, language, and beliefs; and how these relate to ongoing patterns of behavior and 'providers' stereotypes (e.g., they always miss appointments, don't follow instructions, etc). Hatton (1992) argues for the need of translators in hospitals, not just to translate between two different languages, but also to explain divergent concepts and understandings of disease treatment and causation. Johnson and Baboila (1996) are in the process of developing a cross-cultural health care system database in Minnesota. This project is the result of the concerns of several physicians who have noted dangers associated with providing simplified information on culture, such as creating and perpetuating stereotypes of cultural groups, and representing culture as static. They conclude that "knowing and understanding our changing patient populations will enhance the quality of care and minimize the cost of service." Likewise, Frye (1993) has identified core cultural themes that can be integrated into health promotion strategies targeted at refugee populations. Frye argues that the traditional belief structures of such populations are designed to operate within a predictable environment, and not designed to respond to massive social and cultural disorganization. As a result, refugee illnesses are often difficult to diagnose because they are not common experiences among the general Canadian population (e.g., the widespread occurrence of post-traumatic stress disorder).

Perhaps a better solution would be to recognize the true value of traditional health care systems that have evolved to meet the specific needs of certain populations. Pluralistic health care, whether recognized or not, remains a common method of treatment for many persons. In fact, one study in the *New England Journal of Medicine* reports that in 1990 Americans made more visits to providers who offered unconventional therapies than to all primary care physicians combined (425 million compared to 388 million visits) (Eisenberg et al., 1993). Likewise, Olsen (1994) maintains that medical pluralism is important to Natives in Canada. Furthermore, Duggan (1995) reports that the majority of diseases in the U.S. are the result of high-stress lifestyles, and not acute life-threatening diseases. These illnesses are specifically what many traditional and alternative systems of health care have evolved to treat.

Basically, anthropology emphasizes differences over similarities, and qualitative data over quantitative data, through a sensibility to context. Through the research methods of applied medical anthropology, knowledge at the local level can be communicated to those who are creating health care policies at the international level. It is essential that ethnographic knowledge be taken seriously in the planning and implementation of medical research, to assure that low-income, nonwestern peoples benefit as well. In understanding what is at stake for the participants, anthropology can offer a cultural formulation of conflicting ethical priorities (Kleinman, 1995).

It is argued that the ideal pluralistic health care system is a collaborative system (Young, 1994). In a collaborative system, both biomedicine and traditional and alternative systems of health care would realize their strengths and limitations, share resources needed to provide their services adequately, and develop a relationship of mutual trust and respect. While it is apparent that there is a real need to recognize traditional and alternative health care systems and practices, and it is generally agreed that a collaborative system is best suited to accomplish this recognition, in actual practice this is a highly difficult and improbable task. While many argue that a collaborative system is impossible to accomplish in a society in which medicine is treated as a business (see Walker, 1994), my data reveal that it is equally problematic, albeit for different reasons, to implement in a society with a socialized economy.

Perhaps the best we can hope for is what Arthur Kleinman (1995) calls a 'positioned pluralism'. Kleinman (1996:65) argues that in developing international health care policies, the goal should not be agreement on a transcendent universal, but for a positioned pluralism. Recognition of and respect for alternatives (not patronizing attitudes, but genuine expression of the worth of difference) are central to a process that moves from empathic affirmation through critical assessment toward encouragement of contestation, and ultimately to constructive integration or resolution of another sort. The main contribution of medical anthropology, then, is to deeply humanize the process of formulating an ethical problem by allowing variation and pluralism and the reciprocal participatory engagement of knowledge and information across different worlds of experience (Kleinman, 1995:67). In order to accomplish this goal, medical anthropologists must continue to employ the methodologies unique to our discipline; that is, we must continue in our pursuit to understand, advocate, and represent as accurately as possible the multitude of positions presented by those we study with and learn with in the field and at home; and make it our responsibility as students of human nature and culture not to succumb to the larger agendas of the more politically and economically powerful.

The framework presented in chapter seven is not meant to be an end-point in the search for understanding the nature and structure of pluralistic health care systems. Rather, it is hoped that with more field research studies in the area, this model may be refined and developed. In order to do this, more basic field research must be done on pluralistic health care systems around the world. We are witnessing an increasing trend within medical anthropology to study entities as they are conceptualized by biomedicine. This situation is largely the result of an increase in medical anthropologists working in hospitals and other health care institutions, often at the expense of conducting basic research

(Browner, 1999). While the applied work of medical anthropologists is useful, relevant, necessary, and a positive trend for our discipline, the increasing tendency for medical anthropologists to translate their works into biomedical concepts, theory, and practice has left medical anthropology as a discipline in danger of losing its unique perspective. In fact, in the most recent edition of *Medical Anthropology Quarterly*, James Waldram (2000:603) argues that there is a need to return to the field to gather more data on indigenous understandings of efficacy and traditional medical systems, to counteract the biases inherent in the utilization of biomedical understandings and methods characteristic of much previous work. It is my hope that my fieldwork and the production of this thesis have made a contribution to this endeavor.

Bibliography

Ajquejay, F. X.
1993 Gringo Doctor: The Legend and the Legacy. In Richard Luecke (ed.), *A New Dawn in Guatemala: Toward A Worldwide Health Vision*. Prospect Heights, Illinois: Waveland Press, Inc.

Agar, M. and J. MacDonald
1995 Focus Groups and Ethnography. *Human Organization* 54 (1):78-86.

Alvarez Conde, José
1961 *Revisión Indoarqueológica de la Provincia de las Villas*. La Habana: Publicaciones de la Junta, Nacional de Arqueologia y Etnologia.

American Association for World Health
1997 *Denial of Food and Medicine: The Impact of the U.S. Embargo on Health and Nutrition in Cuba.* Washington, DC: American Association for World Health.

Appadurai, A.
1997 *Modernity at Large: Cultural Dimensions of Globalization.* Minneapolis: University of Minnesota Press.

Apter, A.
1991 Herskovits's Heritage: Rethinking Syncretism in the African Diaspora. *Diaspora* 1 (3):235-60.

Asad, T. (ed.)
1973 *Anthropology and the Colonial Encounter*. New York: Humanities Press.

Baer, H. A.
1996 Toward a Political Ecology of Health in Medical Anthropology. *Medical Anthropology Quarterly*10 (4):451-454.

Baer, H.; M. Singer and J. Johnsen
1986 Introduction: Toward a Critical Medical Anthropology. *Social Science and Medicine* 23 (2):95-98.

Baer, H.; M. Singer and I. Susser
1997 *Medical Anthropology and The World System: A Critical Perspective*. London: Bergin andGarvey.

Barkow, J.; L. Cosmides and J. Tooby (eds.)
1992 *The Adapted Mind: Evolutionary Psychology and the Generation of Culture*. New York: Oxford University Press.

Barnett, H. G.
1953 *Innovation: The Basis of Cultural Change*. New York: McGraw-Hill Book Company, Inc.

Barton, J.
1997 *A Political Geography of Latin America*. New York: Routledge.

Bengelsdorf, C. and J. Stubbs
1992 Introduction: Everyday Life In Cuba. In S. Halebsky and J. Kirk (eds.) *Cuba in Transition: Crisis and Transformation, Latin American Perspectives Series, No. 9,* pp:155-160. San Francisco: Westview Press.

Benjamin, J. R.

1977 *The United States and Cuba: Hegemony and Dependent Development, 1880-1934*. Pittsburgh, Pennsylvania: University of Pittsburgh.

Bennett, J. W.
1996 Applied and Action Anthropology: Ideological and Conceptual Aspects. *Current Anthropology* 36 (1):23-53.

Berger, P. and T. Luckmann, T.
1966 *Social Construction of Reality: A Treatise In The Sociology of Knowledge*. New York: Penguin Books.

Bernard, H. R.
1988 *Research Methods in Cultural Anthropology*. Newbury Park: Sage.

Bernard, H. R.; P. Pelto; D. Werner; J. Boster; K. Romney; A. Johnson; C. Ember; and A. Kasakoff
1986 The Construction of Primary Data in Cultural Anthropology. *Current Anthropology* 27 (4): 382-396.

Bernell, D.
1994 The Curious Case of Cuba in American Foreign Policy. *Journal of Inter-American Studies and World Affairs* 36 (2):65-103.

Bock, P. K.
1996 *Rethinking Psychological Anthropology: Continuity and Change in the Study of Human Action*. New York: W. H. Freeman and Company.

Bodekar, G. C.
1994 Traditional Health Care and Public Policy: Recent Trends. In A. Islam and R. Wiltshire (eds.) *Traditional Health Care and Public Policy: Proceedings From an International Workshop,* pp: 96-109. Ottawa: IDRC.

Bonome Moreno, P.; G. Veliz Olivares and Z. Sanchez Alvisa
1994 Social Functions and Evolution of Catholicism in Cuban Society. *Social Compass* 41 (2): 255-271.

Bordieu, P.
1987 *Outline of A Theory of Practice*. Cambridge: Cambridge University Press.

Brock, L. and O. Cunningham
1991 Race and the Cuban Revolution: A Critique of Carlos Moore's 'Castro, the Blacks and Africa.' In L. A. Pérez (ed.) *Cuban Studies, Volume 21,* pp: 171-186. Pittsburgh: University of Pittsburgh Press.

Browner, C. H.
1999 On the Medicalization of Medical Anthropology. *Medical Anthropology Quarterly.* 13 (2): 135-140.

Browner, C. H.; B. O. de Montellano, and A. Rubel
1988 A Methodology For Cross-Cultural Ethno-Medical Research. *Current Anthropology* 29 (5):681-702.

Bryant, J. H.
1980 WHO's Program of Health for All by the Year 2000: A Macrosystem for Health Policy Making – A Challenge to Social Science Research. *Social Science and Medicine* 14A:381-386.

1984 Health Services, Manpower and Universities in Relation to Health for All: An Historical and Future Perspective. *American Journal of Public Health* 74:714-719.

Burns, E. B.

1994 *Latin America: A Concise Interpretive History* (sixth ed.). Englewood Cliffs, New Jersey: Prentice Hall.

Butterworth, D.
1974 Grass-Roots Political Organization in Cuba: A Case of the Committees For the Defense of the Revolution. In W. A. Cornelius and F. Trueblood (eds.) *Latin America Urban Research.*

Anthropological Perspectives on Latin American Urbanization, pp: 183-203. Beverly Hills: Sage.

1980 *The People of Buena Ventura: Relocation of Slum Dwellers in Post-Revolutionary Cuba*. Urbana: University of Illinois Press.

Byng, Richard
1993 Primary Mental Health Care in Nicaragua. *Social Science and Medicine* 36 (5):625-629.

Caldwell, J. C.
1993 Health Transition: The Cultural, Social and Behavioural Determinants of Health in The Third World. *Journal of Social Science and Medicine* 36 (2):125-135.

Cardelle, A.
1994 The Preeminence of Primary Care Within Cuban Predoctoral Medical Education. *International Journal of Health Services* 24 (3):421-429.

Centeno, M. A. and M. Font
1997 Cuba's Search For Alternatives. In M. A. Centeno and M. Font (eds.) *Toward A New Cuba? Legacies of A Revolution*, pp: 9-24. London: Boulder.

Chela, C.
1998 Cuba Shows Health Gains Despite Embargo. *British Medical Journal* 36 (7130):497.

Claiborne, W.
1999 Illinois Governor Defends Visit to Castro. *Washington Post*, October 29:A2.

Clifford, J. and G. Marcus (eds.)
1986 *Writing Culture: The Poetics and Politics of Ethnography*. Berkeley: University of California Press.

Clytus, J.
1970 *Black Man in Red Cuba*. Coral Gables, Florida: University of Miami Press.

Cohen, R.
1989 Human Rights and Cultural Relativism: The Need For a New Approach. *American Anthropologist* 91 (4):1014-1017.

Cole, J.
1978 Afro-American Solidarity with Cuba. *The Black Scholar* 8:73-80.

Commission for Human Rights of the American Anthropological Association
1993 Report of The American Anthropological Association Commission for Human Rights. *American Anthropological Association: Anthropology Newsletter* 34:1,5.

Crandon-Malamud, L.
1997 Phantoms and Physicians: Social Change Through Medical Pluralism. In L. Romanucci-Ross, D. E. Moerman, and L. R. Tancredi (eds.) *The Anthropology of Medicine: From Culture to Method, Third Edition,* pp: 31-58. Westport, Connecticut: Bergin and Garvey.

Crapanzano, V.
1992 *Hermes' Dilemma and Hamlet's Desire: On The Epistemology of Interpretation*. Cambridge: Harvard University Press.

Crozier, R. C.
1968 *Traditional Medicine in Modern China*. Cambridge, Massachusetts: Harvard University Press.

Curto de Casas, S. I.
1994 Health Care in Latin America. In D. Phillips and Y. Verhasselt (eds.) *Health and Development,* pp: 234-248. New York: Routledge.

D'Andradre, R.
1995 Moral Models in Anthropology. *Current Anthropology* 36 (3):581-612.

Danielson, R.
1985 Medicine in The Community. In S. Halebsky and J. Kirk (eds) *Cuba: 25 Years of Revolution, 1959-1984,* pp: 45-61. New York: Prager.

Davis, D.
1995a Afro-Creole Social Consciousness Movements. In D. Davis (ed.) *Slavery and Beyond: The African Impact on Latin America and the Caribbean*, pp: 195-252. Wilmington, Delaware: Scholarly Resources Inc.

1995b Introduction: The African Experience in Latin America - Resistance and Accommodation. In D. Davis (ed.) *Slavery and*

Beyond: The African Impact on Latin America and the Caribbean, pp: xi-xxvi. Wilmington, Delaware: Scholarly Resources Inc.

Davis-Floyd, R.
1992 *Birth as An American Right of Passage.* Berkeley: University of California Press.

Deere, C. D.
1995 The New Agrarian Reforms. *NACLA Report on The Americas* XXIX (2):13-17.

de la Fuente, A. and L. Glasco
1997 Are Blacks "Getting Out of Control"? Racial Attitudes, Revolution, and Political Transition in Cuba. In M. A. Centeno and M. Font (eds.) *Toward A New Cuba?: Legacies of a Revolution,* pp: 53-72. London: Boulder.

DelVecchio-Good, M.
1995 Cultural Studies of Biomedicine: An Agenda for Research. *Social Science and Medicine* 41 (4):461-473.

Díaz-Briquets, S.
1983 *The Health Revolution in Cuba.* Austin: University of Texas Press.

Diaz Cerveto, A. M. Perez Cruz, O. and M. Rodriguez Delgado
1994 Religious Beliefs in Today's Cuban Society: Basic Characteristics According to the Level of Elaboration of the Concept of the Supernatural. *Social Compass* 41 (2):225-240.

Duggan, R.
1995 Complimentary Medicine: Transforming Influence or Footnote to History? *Alternative Therapies* 1 (2):28-33.

Dumont, L.
1986 *Essays on Individualism: Modern Ideology in Anthropological Perspective.* Chicago: The University of Chicago Press.

Dunn, S.
1987 Culture Brokers and Managing the Multicultural Hospital. *Hospital Topics* 65 (5):27-29.

Eberstadt, N.
1986 Did Fidel Fudge the Figures? Literacy and Health: The Cuban Model. *Caribbean Review* 15 (2):5-7, 37-38.

Eisenberg, D.; R. Kessler, and C. Foster
1993 Unconventional Medicine in the United States: Prevalence, Cost and Patterns of Use *New England Journal of Medicine* 328:246-252.

Elkadi, A.
1994 Traditional Health Services in the Middle East: Spiritual Aspects of Healing and Their Scientific Bases. In A. Islam and R. Wiltshire (eds.) *Traditional Health Systems and Public Policy: Proceedings From An International Conference,* pp: 148-167. Ottawa: IDRC.

Entralgo, A. and D. G. López
1995 Cuban Policy for Africa. In D. Davis (ed.) *Slavery and Beyond: The African Impact on Latin America and the Caribbean,* pp: 265-277. Wilmington, Delaware: Scholarly Resources Inc.

Farinas Gutierrez, M. D.
1994 L'influence de la Religiosité sur la Transculturation à Cuba: une Question pour les Chercheurs. *Social Compass* 41 (2):241-254.

Farquhar, J.
1994 *Knowing Practice: The Clinical Encounter of Chinese Medicine.* Boulder, Colorado: Westview Press.

Feinsilver, J.
1989 Cuba as a "World Medical Power": The Politics of Symbolism. *Latin American Research Review* 24 (2):1-34.

Fernández Revuelta, A.
1999 *Castro's Daughter: An Exile's Memoir of Cuba.* New York: Griffin.

Finkler, K.
1981 Dissident Religious Movements in the Service of Women's Power. *Sex Roles* 7 (5):481-495.

1983 Dissident Sectarian Movements, the Catholic Church, and Social Class in Mexico. *Comparative Studies in Society and History* 25 (2):277-305.

1991 *Physicians at Work, Patients in Pain.* Boulder, Colorado: Westview Press.

1998 Sacred Healing and Biomedicine Compared. In P. Brown (ed.) *Understanding and Applying Medical Anthropology,* pp:118-128. Mountain View, California: Mayfield Publishing.

Fleitas Salazar, C. R.
1998 La Homeopatía en Santiago de Cuba Durante El Siglo XIX. *Del Caribe* 28:113-118.

Forgac, Z.
1994 *Methods of Combining Biomedicine With Traditional Medicine: The Chinese Example*. Edmonton, Alberta: Centre for the Cross-Cultural Study of Health and Healing, University of Alberta.

Frank, G.
1969 *Latin America: Underdevelopment or Revolution?* New York: Monthly Review Press.

Frideres, J.
1988 *Native People in Canada: Contemporary Conflicts, Third Edition*. Scarborough: Prentice-Hall.

Friedman, J.
1994 *Cultural Identity and Global Processes*. London: Sage.

Frye, B. A.
1993 Use of Cultural Themes in Promoting Health Among Southeast Asian Refugees. *American Journal of Health Promotion* 9 (4):269-280.

Fuentes, C.
1985 *Latin America: At War With the Past*. Toronto: CBC Enterprises.

Garfield, R. and S. Santana
1997 The Impact of the Economic Crisis and the US Embargo on Health Care in Cuba. *American Journal of Public Health* 87:15-20.

Garro, L. C.
1998a On The Rationality of Decision-Making Studies: Part 1: Decision Models of Treatment Choice. *Medical Anthropology Quarterly* 12 (3):319-340.

1998b On the Rationality of Decision-Making Studies: Part 2: Divergent Rationalities. *Medical Anthropology Quarterly* 12 (3):341-355.

Geertz, C.
1995 *After The Fact: Two Countries, Four Decades, One Anthropologist*. Cambridge: Harvard University Press.

Gellner, E.
1985 *Relativism and The Social Sciences*. New York: Cambridge University Press.

Gerth, H. H. and C. W. Mills
1958 *From Max Weber: Essays in Sociology*. New York: Oxford University Press.

Gessler, W.
1994 The Global Pharmaceutical Industry: Health, Development and Business. In D. Phillips and Y. Verhasselt (eds.) *Health and Development,* pp:97-108. New York: Routledge.

Gilmore, D.
1990 *Manhood in the Making: Cultural Concepts of Masculinity*. New Haven: Yale University Press.

Good, B.J. And M.J. DelVecchio-Good
1993 Learning Medicine: The Constructing of Medical Knowledge at Harvard Medical School. In M. Lock and S. Lindenbaum (eds.) *Knowledge, Power and Practice: The Anthropology of Medicine and Everyday Life*, pp:81-107. San Francisco: University of California Press.

Good, M.; L. Hunt; T. Munakata; and Y. Kobayashi
1992 A Comparative Analysis of Biomedicine: Disclosure and Consequences for Treatment in The Practice of Oncology. In P. Conrad and E. Gallagher (eds.) *Health and Health Care in Developing Countries: Sociological Perspectives,* pp 180-210. Philadelphia: Temple University Press.

Gordon, D.
1990 Embodying Illness, Embodying Cancer. *Culture, Medicine and Psychiatry* 14 (273):112-119.

1993 The Unhappy Relationship of Feminism and Post-Modernism in Anthropology. *Anthropology Quarterly* 66 (3):109-117.

Gough, I. and T. Thomas
1994 Why Do Levels of Human Welfare Vary Among Nations? *International Journal of Health Services* 24 (4):715-748.

Greenough, P.
1995 Global Immunization and Culture: Compliance and Resistance in Large- Scale Primary Health Campaigns. *Social Science and Medicine* 41 (5):605-660.

Grolier's
1996 *Grolier: Multimedia Encyclopedia.*

Guevara, E. [Che]
1960 On Revolutionary Medicine. In J. Gerassi (ed.) *Venceremos! The Speeches and Writings of Che Guevara*, pp: 112-119. New York: Simon and Schuster.

Hahn, R.
1995 *Sickness and Healing: An Anthropological Perspective*. London: Yale University Press.

Hahn, R. And A. Gaines (eds.)
1985 *Physicians of Western Medicine.* Dordrecht, Netherlands: D. Reidel Publishing Company.

U.S. Government Printing Office
1941 *The Handbook of the South American Indians Volume IV.* Washington: United States Government Printing Office.

Handler, R.
1991 An Interview With Clifford Geertz. *Current Anthropology* 32 (5):603-613.

Hannerz, U.
1990 Cosmopolitans and Locals in World Culture. *Theory, Culture and Society* 7 (2):237-251.

1992a *Cultural Complexity: Studies in the Social Organization of Meaning*. New York: Columbia University Press.

1992b The Global Ecumene as a Network of Networks. In A. Kuper (ed.) *Conceptualizing Society,* pp: 34-56. New York: Routledge.

1996 *Transnational Connections*. New York: Routledge.

Hardin, R.
1990 Ethics and Stochastic Processes. *Social Philosophy Policy* 7:69-80.

Harris, G.
1989 Concepts of the Individual, Self, and Person in Description and Analysis. *American Anthropologist* 91:599-612.

Hastrup, K. and P. Elsass
1990 Anthropological Advocacy: A Contradiction in Terms? *Current Anthropology* 31 (3):301-11.

Hatch, E.
1997 The Good Side of Relativism. *Journal of Anthropological Research* 53 (3):371-381.

Hatton, D.
1992 Information Transmission in Bilingual, Bicultural Contexts. *Journal of Community Health Nursing* 9 (1):53-59.

Heggenhougen, K.
1995 The Epidemiology of Functional Apartheid and Human Rights Abuses. *Social Science and Medicine* 40:281-284.

Hemmes, M.
1994 Cuba: Its Health Care System May Offer Lessons (Positive and Negative) For U.S. Policy Makers. *Hospitals and Health Networks* 68 (9):52-54.

Hill, K.
1983 An Evaluation of Cuban Demographic Statistics, 1938-1980. In P. E. Hollerbach and S. Díaz_Briquets (eds.) *Fertility Determinants in Cuba,* Washington, D.C.: National Academy Press.

Hollan, D.
1992 Cross-Cultural Differences in the Self. *Journal of Anthropological Research* 48 (4):283-300.

Hopkins, J.
1987 *Latin America: Perspectives on a Region*. New York: Holmes & Meier, Inc.

Holtz, T.
1997 *Summary of Issue of HIV/AIDS in Cuba: American Public Health Association Cuba Tour, August 1997.* http://www.igc.org/cubasoli/cubahol2.html (Feb. 3, 2000)

Hudelson, P.
1993 ORS and the Treatment of Childhood Diarrhea in Managua, Nicaragua. *Social Science and Medicine* 37 (1):97-103.

Hufbauer, G., K. Elliot, and J. Schott
1990 *Economic Sanctions Reconsidered*. Washington, DC Institute for International Economics.

Hugh-Jones, S.
1992 Yesterday's Luxuries, Tomorrow's Necessities: Business and Barter in Northwest Amazonia. In C. Humphrey and S. Hugh-Jones (eds.) *Barter, Exchange and Value: An Anthropological Approach*, pp:1-20. Cambridge: Cambridge University Press.

Hyna, B. and A. Ramesh
1994 Traditional Medicine: Its Extent and Potential for Incorporation into Modern National Health Systems. In D. Phillips and Y. Verhasselt (eds.) *Health and Development,* pp: 65-82. New York: Routledge.

Iatridis, D.
1990 Cuba's Health Care Policy: Prevention and Active Community Participation. *Social Work* 35 (1):29-35.

James, W.
1995 Introduction: What Ever Happened to The Enlightenment? In W. James (ed.) *The Pursuit of Certainty: Religious and Cultural Formations,* pp: 1-14. New York: Routledge.

Jenks, L. H.

1970 *Our Cuban Colony: A Study in Sugar*. New York: Arno Press & The New York Times.

Johnson, H.
1964 *The Bay of Pigs: The Leaders' Story of Brigade 2506.* New York: W. W. Norton & Company.

Johnson, A. E. and G. V. Baboila
1996 Integrating Culture and Healing: Meeting the Health Care Needs of a Multicultural Community. *Minnesota Medicine* 79:41-45.

Jornados Popolares de Salud
(n.d.) *El Mejor Alimento*. Managua, Nicaragua Libre Jornadas Populares de Salud.

Kamat, V.
1995 Reconsidering the Popularity of Primary Health Centres in India: A Case Study From Rural Maharashtra. *Social Science and Medicine* 41 (1):87-98.

Karim, W. J.
1996 Anthropology Without Tears: How a 'Local' Sees the 'Local' and the 'Global'. In H. L. Moore (ed.) *The Future of Anthropological Knowledge* pp: 115-138. New York: Routledge.

Keane, C.
1998 Globality and Constructions of World Health. *Medical Anthropology Quarterly* 12 (2): 227-240.

Kennedy, R. F.
1971 T*hirteen Days: A Memoir of the Cuban Missile Crisis*. New York: W.W. Norton & Co.

Klein, H.

1967 *Slavery in the Americas*. Chicago: Quandrangle Books.

Kleinman, A.
1974 Social, Cultural and Historical Themes In The Study of Medicine in Chinese Societies: Problems and Prospects For The Comparative Study of Medicine and Psychiatry. In A. Kleinman (ed.) *Medicine in Chinese Cultures,* pp: 589-645. Washington, D. C.: Department of Health Education and Welfare.

1980 *Patients and Healers In The Context of Culture*. Berkeley: University of California Press.

1995 *Writing at the Margin: Discourse Between Anthropology and Medicine*. Berkeley: University of California Press.

Kluckhohn, C.
1955 Ethical Relativity: Sic et Non. *Journal of Philosophy* 52:663-677.

Knight, F. W.
1970 *Slave Society in Cuba During the Nineteenth Century*. London: University of Wisconsin Press.

Kottack, C.
1996 The Media, Development and Social Change. In E. Moran (ed.) *Transforming Societies, Transforming Anthropology,* pp: 135-164. Ann Arbour: University of Michigan Press.

Krinsky, M. and D. Golove (eds.)
1993 *United States Economic Measures Against Cuba*. Northampton, Massachusetts: Aletheia Press.

Krueger, R.
1994 *Focus Groups: A Practical Guide for Applied Research*. Thousand Oaks, California: Sage Publications.

Kuntz, D.
1994 The Politics of Suffering: The Impact of the U.S. Embargo on The Health of The Cuban People: Report of a Fact-Finding Trip to Cuba, June 6-11, 1993. *International Journal Of Health Services* 24 (1):161-179.

LaFond, A.
1995 Case Studies: Why An Immunization Programme Failed to Make its Mark on Women: Somalia. In H. Slim and P. Thomson (eds.) *Listening for a Change: Oral Testimony and Community Development,* pp: 95-103. Philadelphia: New Society Publishers.

Lather, P.
1986 Issues of Validity in Openly Ideological Research: Between a Rock and a Soft Place. *Interchange* 17 (4):63-84.

Laurell, A. C.
1989 Social Analysis of Collective Health in Latin America. *Social Science and Medicine* 28 (11):1183-1190.

Lee, D.
1974 *Freedom and Culture*. Engelwood Cliffs, New Jersey: Prentice Hall.

Lefever, H. G.
1996 When the Saints Go Riding In: Santeria in Cuba and the United States *Journal for the Scientific Study of Religion* 35 (3):318-330.

Leiner, M.
1994 *Sexual Politics in Cuba: Machismo, Homosexuality and AIDS.* Boulder, Colorado: Westview Press.

Leslie, C.
1992 Interpretations of Illness: Syncretism in Modern Ayurveda. In Charles Leslie and Allan Young (eds.) *Paths to Asian Medical Knowledge,* pp: 177-208. Berkeley: University of California Press.

Lewis, G.
1993 Double Standards in Treatment Evaluation. In M. Lock and S. Lindenbaum (eds.) *Knowledge, Power and Practice,* pp: 189-218. Berkeley: University of California Press.

Lewis, O.
1974 Culture of Poverty. In D. Heath (ed.) *Contemporary Cultures and Societies of Latin America, Second Edition*, pp: 469-479. New York: Random House.

Lewis, O.; R. Lewis. and S. Rigdon
1977a *Four Men: Living the Revolution. An Oral History of Contemporary Cuba.* Urbana: University of Illinois Press.

1977b *Four Women: Living the Revolution. An Oral History of Contemporary Cuba.* Urbana: University of Illinois Press.

1978 *Neighbours: Living the Revolution. An Oral History of Contemporary Cuba.* Urbana: University of Illinois Press.

Loker, W. (ed.)
1999 *Globalization and the Rural Poor in Latin America*. London: Lynne Rienner Publishers.

Long, A.
1996 Globalization and Localization: New Challenges to Rural Research. In H. Moore (ed.) *The Future of Anthropological Knowledge*, pp: 37-39. New York: Routledge; pp: 37-59.

MacCormick, C. P.
1988 Health and the Social Power of Women. *Social Science and Medicine* 26 (7):677-683.

Machín, A. N.
1987 Angel Santana Suárez: Cuban Sugar Worker. In W. Beezley and J. Ewell (eds.) *The Human Tradition in Latin America: The Twentieth Century,* pp: 75-88. Wilmington, Delaware: Scholarly Resources Inc.

Marable, M.
1984 Race and Democracy in Cuba. *The Black Scholar* 14:22-37.

Marcus, G. and M. Fisher
1986 *Anthropology as Cultural Critique: An Experimental Moment in the Human Sciences.* Chicago: University of Chicago Press.

Mas Largo, P., R. Bravo, J.K. Andrus, M. M. Comellas, M. A. Galindo, C. A. de Quadros, and E. Bell
1994 Lessons From Cuba: Mass Campaign Administration of Trivalent Oral Poliovirus Vaccine and Seroprevalence of Poliovirus Neutralizing Antibodies. *Bulletin of WHO* 72: 221-225.

Mathews, H.
1998 Methodological Approaches to the Study of Reasoning. *Medical Anthropology Quarterly* 12 (3):358-341.

Mauss, M.
1969 *The Gift: Forms and Functions of Exchange in Archaic Societies.* London: Routledge.

McFayden, D.
1995 The Social Repercussions of The Crisis NACLA Report on The Americas 19 (2):20-22.

McGarrity, G. L.
1992 Race, Culture, and Social Change in Contemporary Cuba. In S. Halebsky and J. M. Kirk (eds.) *Cuba In Transition: Crisis and Transformation,* pp: 193-206. San Francisco: Westview Press.

McGlynn, F. and A. Tuden
1991 *Anthropological Approaches to Political Behaviour*. Pittsburgh: University of Pittsburgh Press.

Mendoz, J. P.
1999 Abortion Among Adolescents in Cuba. *Journal of Adolescent Health* 24 (1):59-62.

Messer, Ellen
1993 Anthropology and Human Rights. *Annual Review of Anthropology* 22:221-249.

1997 Pluralist Approaches To Human Rights. *Journal of Anthropological Research* 53 (3):293-318.

Michrina, B. P. and C. Richards
1996 *Person to Person: Fieldwork Dialogue and the Hermeneutic Method*. Albany: State University of New York Press.

Miles, A.
1998 Science, Nature and Tradition: The Mass-Marketing of Natural Medicine in Urban Equador. *Medical Anthropology Quarterly* 12 (2):206-225.

Minkowski, A.
1973 Health of Mother and Child: the Experience in The People's Republic of China, The Democratic Republic of Vietnam and Cuba. *Impact of Science on Society* 23 (1):29-42.

Ministerio de Salud Pública (MINSAP)
1995 *Plantas Medicinales y Tóxicas que la Población Debe Conocer*. La Habana: MINSAP.

2000 *Carpeta Metodológica 1999-2000*, Republica de Cuba. La Habana: MINSAP.

Monge Oveido, R.
1992 Are We or Aren't We? *NACLA Report on the Americas* 254 (4):19.

Montejo, E.
1995 A Cuban Slave's Testimony. In D. Davis (ed.) *Slavery and Beyond: The African Impact on Latin America and the Caribbean*, pp: 11-28. Wilmington, Delaware: Scholarly Resources Inc.

Moore, H. L.
1996 The Changing Nature of Anthropological Knowledge. In H. L. Moore (ed.) *The Future of Anthropological Knowledge*, pp: 1-15. New York: Routledge.

Morgan, L. M.
1990 International Politics and Primary Health Care in Costa Rica. *Social Science and Medicine* 30 (2):211-219.

Morse, J. M.; D. E. Young, and L. Swartz
1991 Cree Indian Healing Practices and Western Health Care: A Comparative Analysis. *Social Science and Medicine* 32 (12):1361-1366.

Murphy, J. M.
1988 *Santeria: An African Religion in America.* Boston: Beacon Press.

Mwabu, G. M.
1986 Health Care Decision at the Household Level: Results of A Rural Health Survey in Kenya. *Social Science and Medicine* 22(3): 315-319.

Nagengast, C.
1997 Women, Minorities and Indigenous Peoples: Universalism and Cultural Relativity. *Journal of Anthropological Research* 53 (3):349-370.

Nagengast, C. and T. Turner
1997 Universal Human Rights Versus Cultural Relativity. *Journal of Anthropological Research* 53 (3):269-272.

Nayeri, K.
1995 The Cuban Health Care System and Factors Currently Undermining It. *Journal of Community Health* 20 (4):321-334.

Nichter, M.
1995 Vaccinations in the Third World: A Consideration of Community Demand. *Social Science and Medicine* 41 (5):617-632.

Nussbaum, M. C.
1993 Non-Relative Virtues: An Aristotelian Approach. In M.C. Nussbaum and A. Sen (eds.) *The Quality of Life,* pp: 242-269. New York: Oxford University Press.

Odebiyi, A. I.
1990 Western Trained Nurses' Assessment of Different Categories of Traditional Healers in Southwestern Nigeria. *International Journal of Nursing Studies* 27 (4):333-342.

Olsen, E.
1994 *Developing Native Health Services in Canada: Beyond the Health Transfer Policy.* Edmonton: Centre for the Cross-cultural Study of Health and Healing.

O'Neil, J. D.
1986 The Politics of Health in the Fourth World: A Northern Canadian Example. *Human Organization* 45 (2):119-128

Oppenheimer, A.
1993 *Castro's Final Hour*. New York: Touchstone.

Orlove, B.
1999 Working in the Field: Perspectives on Globalization in Latin America. In W. M. Loker (ed.) *Globalization and the Rural Poor in Latin America,* pp: 195-203. London: Lynne Rienner Publishers.

Ortiz, F.
1991 *Estudios Ethnosociológicos.* La Habana: Pensamiento Cubano: Editorial De Ciéncias Sociales.

Ott, T.
1973 *The Haitian Revolution.* Nashville: University of Tennessee Press.

Oxhorn, P.
1998 Is the Century of Corporatism Over? Neoliberalism and the Rise of Neopluralism. In P. Oxhorn and G. Ducatenzeiler (eds.) *What Kind of Democracy? What Kind of Market? Latin America in the Age of Neoliberalism.* Pennsylvania: University of Pennsylvania Press.

Pachter, L.
1994 Culture and Clinical Care: Folk Illness Beliefs and Behaviours and their Implications for Health Care Delivery. *Journal of the American Medical Association* 271 (9):690-694.

Pachter, L.M.; B. Bernstein; and Osorio, A.
1992 Clinical Implications of a Folk Illness: *Empacho* in Mainland Puerto Ricans. *Medical Anthropology Quarterly* 13: 285-299.

Pan-American Health Organization (PAHO)
1985 *Health of Women in the Americas*. Washington, D. C.: PAHO

Pastor, M.
1996 Cuba and Cuban Studies: Crossing Boundaries During a "Special Period." *Latin American Research Review* 31 (3):218-234.

Pastor, M. and A. Zimbalist
1995 Cuba's Economic Conundrum. *NACLA Report on the Americas* 29 (2):7-12.

Paterson, T. G.

1994 *Contesting Castro: The United States and the Triumph of the Cuban Revolution.* New York: Oxford University Press.

Paxman, J. M.; A. Rizo; L. Brown; and J. Benson
1993 The Clandestine Epidemic: The Practice of Unsafe Abortion in Latin America. *Family Planning* 24 (4):205-226.

Pearce, T. O.
1993 Lay Medical Knowledge in an African Context. In M. Lock and S. Lindenbaum (eds.) *Knowledge, Power and Practice: The Anthropology of Everyday Life*, pp: 150-165. Berkeley: University of California at Berkeley Press.

Pederson, D. and V. Baruffati
1989 Healers, Deities, Saints and Doctors: Elements For The Analysis of Medical Systems. *Social Science and Medicine* 29 (4):487-496.

Pelto, P. J.
1992 Anthropological Research Methods and Applications: Taking Stock. In J. J. Poggie , B. R. Walt and W. W. Dressler (eds.) *Anthropological Research Processes and Application*. New York: SUNY Press.

Pelto, P. J. and G. H. Pelto
1997 Studying Knowledge, Culture, and Behaviour in Applied Medical Anthropology. *Medical Anthropology Quarterly* 11 (2):147-163.

Pérez-Stable, M.
1991 The Field of Cuban Studies. *Latin American Research Review.* 26 (2): 239-251.

Pérez, L.
1995 *Cuba: Between Reform and Revolution.* New York: Routledge.

Pérez, L. and Mena. A. I.
1991 *Speaking With the Dead: Development of Afro-Latin Religion Among Puerto Ricans in the United States.* New York: AMS Press.

Pilgrim, D. and A. Rogers
1995 Mass Childhood Immunization: Some Ethical Doubts For Primary Health Care Workers. *Nursing Ethics* 2 (1):63-70.

Potts, R.
1999 Medicina Natural: Una Revolución Verde. *Avances Médicos de Cuba* 6 (20):44-46.

Puntenney, P. J.
1996 Global Ecosystems: Creating Options Through Anthropological Perspectives. *NAPA Bulletin No. 15*. Washington, D.C.: American Anthropological Association.

Rabinow, P.
1991 For Hire: Resolutely Late Modern. In R. G. Fox (ed.) *Recapturing Anthropology: Working in the Present,* pp: 59-72. Santa Fe, New Mexico: School of American Research Press.

Ramirez Calzadilla, J.
1994a Introduction. *Social Compass* 41 (2):195-202.

1994b Les Recherches Socio-Religieuses à Cuba: Définitions Théoriques, Méthodologiques et Conceptuelles. *Social Compass* 41 (2):203-223.

Rappaport, R.
1994 Disorders Of Our Own: A Conclusion. In S. Forman (ed.) *Diagnosing America: Anthropology and Public Engagement,* pp:234-294. Ann Arbour, Michigan: University of Michigan Press.

Robertson, R.
1991 Globality, Global Culture and Images of World Order. In H. Haferkampf and N. Smelser (eds.) *Social Change and Modernity*, pp: 395-411. Los Angelos: University of California Press.

Román, G.
1994 Epidemic Neuropathy in Cuba: A Plea to End The United States Economic Embargo on a Humanitarian Basis. *Neurology* 44:1784-1786.

Rosaldo, R.
1989 *Culture and Truth: The Remaking of Social Analysis*. Boston: Beacon Press.

Rosendhal, M.
1997 *Inside The Revolution: Everyday Life In Socialist Cuba*. Ithaca, New York: Cornell University Press.

Rosenthal, M.
1992 The Problems of Single Motherhood in Cuba. In S. Halebsky and J. M. Kirk (eds.) *Cuba In Transition: Crisis and Transformation*, pp: 161-176. San Francisco: Westview Press.

Rosset, P. and M. Benjamin
1995 *The Greening of the Revolution: Cuba's Experiment with Organic Farming*. Sydney, Australia: Ocean Press.

Rudolph, J. D.
1985 *Cuba: A Country Study, Third Edition*. Washington: Government Printing Office.

Ruffin, P.
1990 *Capitalism and Socialism in Cuba: A Study of Dependency, Development and Underdevelopment*. London: Macmillan Press.

Sahlins, M.
1972 *Stone Age Economics*. New York: Atherton Inc.

Said, H. M.
1994 Traditional Health Systems: National Policy Issues and Directions. In Islam and R. Wiltshire (eds.) *Traditional Health Systems and Public Policy: Proceedings of An International Workshop*, pp:143-147. Ottawa: IDRC.

Sanders, D.
1985 *The Struggle for Health: Medicine and the Politics of Underdevelopment*. London: MacMillan Education Ltd.

Sandoval, M. C.
1979 Santeria as a Mental Health Care System: An Historical Overview. *Social Science and Medicine* 13:137-151.

Santana, S.
1987 The Cuban Health Care System: Responsiveness to Changing Population Needs and Demands. *World Development* 15 (1):113-125.

1988 Some Thoughts on Vital Statistics and Health Status. In A. Zimbalist (ed.) *Cuban Politcal Economy: Controversies in Cubanology,* pp:107-118. Boulder, Colorado: Westview Press.

Scheper-Hughes, N.
1990 Three Propositions for A Critically Applied Medical Anthropology. *Social Sciences and Medicine* 30 (2):189-197.

Sen, A.
1993 Capability And Well-Being In The Quality of Life. In S. C. Nussbaum and A. Sen (eds.) *The Quality of Life,* pp: 30-61. New York: Oxford University Press.

1994 Objectivity and Position: Assessment of Health and Well-Being. In L. C. Chen, A. Kleinman and N. Ware (eds.) *Health and Social Change In International Perspective,* pp:115-128. Boston: Harvard University Press.

Seoane Gallo, J.
1993 *El Folclor Médico de Cuba: Enfermedades Infecciosas.* La Habana: Editorial de Ciencias Sociales.

Shamsul, A. B.
1995 Inventing Certainties: The Dakwah Persona in Malaysia. In W. James (ed.) *The Pursuit of Certainty: Religious and Cultural Formations,* pp: 112-133. New York: Routledge.

Sherriff, R.
2000 Exposing Silence as Cultural Censorship: A Brazilian Case. *American Anthropologist* 102 (1):114-132.

Shimkin, D.
1996 Culture Change and Health: Third World Perspectives. In E.

Moran (ed.) *Transforming Societies, Transforming Anthropology,* pp: 265-300. Ann Arbor: University of Michigan.

Shore, B.
1996 *Culture in the Mind: Cognition, Culture and the Problem of Meaning*. Oxford: Oxford University Press.

Short, M.
1993 *Law and Religion in Marxist Cuba: A Human Rights Inquiry*. New Brunswick: Transaction.

Shorter, E.
1985 *Bedside Manners*. New York: Simon and Schuster.

Simons, G.
1994 *The United Nations: A Chronology of Conflict*. New York: St. Martin's Press.

Singer, M.
1996 Farewell To Adaptationism: Unnatural Selection and the Politics of Biology. *Medical Anthropology Quarterly* 10 (4):496-515.

Singer, M. and Baer, H.
1995 *Critical Medical Anthropology*. Amityville, New York: Baywood Press.

Singh, S. and D. Wulf
1991 Estimating Abortion Levels in Brazil, Columbia and Peru Using Hospital Admissions and Faculty Survey Data. *International Family Planning Perspectives* 17 (1):8-13.

Skidmore, T. E. and P.H. Smith

1992 *Modern Latin America* (third ed.). New York: Oxford University Press.

Smith, H. W.
1981 *Strategies of Social Research: The Methodological Imagination*. Englewood Cliffs, New Jersey: Prentice Hall.

Smith, L. M. and A. Padula
1988 Women Workers in Socialist Cuba, 1959-1988: Progress and Problems. *Ibero-Americana: Nordic Journal of Latin American Studies* 18:33-55.

1996 *Sex and Revolution: Women in Socialist Cuba*. New York: Oxford

University Press.

1997 *Gender Ideology and Psychological Reality: An Essay on Cultural Reproduction*. New Haven: Yale University Press.

Spradley, J. P.
1979 *The Ethnographic Interview*. New York: Holt, Rinehart and Winston.

Stanley, D.
1997 *Cuba*. Hawthorn, Australia: Lonely Planet Publications.

Stewart, D.
1990 *Focus Groups: Theory and Practice*. Newbury Park, California: Sage.

Stone, L.
1992 Cultural Influences in Community Participation in Health. *Social Science and Medicine* 35 (4):409-417.

Suchlicki, J.
1974 *Cuba: From Columbus to Castro*. New York: Charles Scribner's Sons.

Susser, M.
1993 Health as a Human Right: An Epidemiologist's Perspective on Public Health. *American Journal of Public Health* 83 (3):418-426.

Sutherland, R. and J. Fulton
1992 *Health Care In Canada: A Description and Analysis of Canadian Health Services*. Ottawa: The Health Group.

Swanson, J.
1988 Health-Care Delivery in Cuba: Nursing's Role In Achievement of The Health For All. *International Journal of Nursing Studies* 25 (1):11-21.

Swanson, K. A.; J. M. Swanson; A. E. Gill; and C. Walter
1995 Primary Care in Cuba: A Public Health Approach. *Health Care for Women International* 16:299-308.

Tannenbaum, F.
1946 *Slave and Citizen: The Negro in the Americas*. New York: Vintage Books.

Taussig, M.
1980 *The Devil and Commodity Fetishism in Latin America*. Chapel Hill: The University of North Carolina.

Taylor, C.
1994 The Politics of Recognition. In A. Gutmann (ed.) *Multiculturalism,* pp: 25-74. Princeton, New Jersey: Princeton University Press.

Thompson, R. F.
1983 *Flash of the Spirit: African and Afro-American Art and Philosophy.* New York: Vintage Books.

Trotter. R. T.
1991 Ethnographic Research Methods For Applied Medical Anthropology. In C. E. Hill (ed.) *Training Manuel in Applied Medical Anthropology*. Washington, D. C.: American Anthropological Association.

Tucker, K. and T. R. Hedges
1993 Food Shortages and an Epidemic of Optic and Peripheral Neuropathy in Cuba. *Nutrition Reviews* 51 (12):349-357.

UNICEF
1996 *The State of the World's Children*. Geneva: World Health Organization.

Vilariño Ruiz, E.
1998 *Cuba: Reforma y Modernización Socialistas.* La Habana: Editorial José Martí.

Vuori, H.
1982 The World Health Organization and Traditional Medicine. *Community Medicine* 4:129-137.

Waitzkin, H. And T. Britt
1989 Changing the Structure of Medical Discourse: Implications of Cross-National Comparisons. *Journal of Health and Social Behaviour* 30 (4):436-449.

Waitzkin, H., K. Wald, R. Kee, R. Danielson, and L. Robinson
1997 *Primary Care in Cuba: Low and High Technology Developments Pertinent To Family Medicine*. Paper submitted to the Division of Community Medicine, Department of Family and Community Medicine, University of New Mexico.

Wald, K.
1990 AIDS In Cuba: A Dream or A Nightmare? *Z Magazine* 104-109.

Waldram, J.
1990 Access to Traditional Medicine in a Western Canadian City. *Medical Anthropology Quarterly* 12:325-348.

2000 The Efficacy of Traditional Medicine: Current Theoretical and Methodological Issues. *Medical Anthropology Quarterly* 14 (4):603-625.

Walker, M. J.
1994 *Dirty Medicine: Science, Big Business and the Assault on Natural Health Care.* London: Slingshot Publications.

Wallace, A.
1961 *Culture and Personality*. New York: Random House.

Wallerstein, I.
1974 *The Modern World System*. New York: Academic Press.

Wartofsky, M. W.
1982 Medical Knowledge as a Social Product: Rights, Risks, and Responsibilities. In W. Bonderson, H. T. Engelhardt, S. F. Spicker and J. M. White (eds.) *New Knowledge in the Biomedical Sciences,* pp:113-130. New York: D. Reidel Publishing Company.

Weatherford, J.
1988 *Indian Givers: How the Indians of the Americas Transformed the World.* New York: Fawcett Columbine.

Weber, M.
1947 *The Theory of Social and Economic Organization*. Glencoe, Illinois: The Falcon's Wing Press.

Weil, A.
1988 *Health and Healing.* Boston: Houghton Mifflin Company.

Weller, S. C.; T. K. Ruebush, and R. E. Klein
1991 An Epidemiological Description of a Folk Illness: A Study of *Empacho* in Guatemala. *Medical Anthropology* 13 (1):19-31.

Weller, S. C.; L. M. Pachter, R. T. Trotter, and R. D. Bear
1993 *Empacho* in Four Latino Groups: A Study of Intra- and Inter-Cultural Variation in Belief. *Medical Anthropology* 15 (1): 109-136.

Werbner, P.
1995 Powerful Knowledge In A Global Sufi Cult: Reflections On The Poetics of Travelling Theories. In W. James (ed.) *The Pursuit of Certainty: Religious and Cultural Formations*, pp: 134-160. New York: Routledge.

Whiteford, M.
1999 Homeopathic Medicine in the City of Oaxaca, Mexico: Patients' Perspectives and Observations. *Medical Anthropology Quarterly* 13 (1):69-78.

Wolf, E.
1982 *Europe and the People Without History*. Berkeley: University of California Press.

World Bank
1993 *World Development Report: Investing in Health*. Oxford: Oxford University Press.

World Health Organization (WHO)
1978 *International Conference on Primary Health Care: Declaration of Alma-Alta*. USSR.

1979 *Formulating Strategies for Health for All by the Year 2000*. Geneva, Switzerland.

1983 *Traditional Medicine and Health Care Coverage*. Geneva: WHO.

1995 *The World Health Report 1995: Bridging the Gaps*. Geneva: WHO.

1996 *Fact Sheet n. 134*. Geneva: WHO Information.

1998 *Basic Indicators for All Member States*, information received at http://www.who.int/whr/1999/en/annex1.htm

1999 *The World Health Report 1999*. Geneva: WHO.

Yoder, P.S.
1997 Negotiating Relevance: Belief, Knowledge and Practice in International Health Projects. *Medical Anthropology Quarterly* 11 (2):131-146.

Young, A.
1983 The Relevance of Traditional Medical Cultures to Modern Primary Health Care. *Social Science and Medicine* 17 (16):1205-1211.

1993 A Description of How Ideology Shapes Knowledge of a Mental Disorder (Posttraumaic Stress Disorder). In M. Lock and S. Lindenbaum (eds.) *Knowledge, Power and Practice: The Anthropology of Everyday Life,* pp:108-128. Berkeley: University of California Press.

Young, D.
1994 Models of Health Care Pluralism. In A. Islam and R. Wiltshire (eds.) *Traditional Health Systems and Public Policy: Proceedings of An International Workshop*, pp:62-70. Ottawa: IDRC.

Young, D. and J. G. Goulet
1994 Theoretical and Methodological Issues. In D. Young and J. G. Goulet (eds.) *Being Changed by Cross-Cultural Encounters: The Anthropology of Extra-Ordinary Experience*, pp: 298-335. Peterbourough: Broadview Press.

Young, D.; G. Ingram; M. Liu, and C. MacIntosh
1995 The Dilemma Posed By Minority Medical Traditions In Pluralistic Societies: The Case of China and Canada. *Ethnic and Racial Studies* 18 (3):494-513.

Zechenter, E. M.
1997 In the Name of Culture: Cultural Relativism and The Abuse of The Individual. *Journal of Anthropological Research* 53 (3):319-348.

Zhang, X.
1994 WHO's Policy and Activities on Traditional Medicine. In A. Islam and R. Wiltshire (eds.) *Traditional Health Systems and Public Policy: Proceedings of An International Workshop,* pp:139-142. Ottawa: IDRC.

Zieba, R.
1990 *Healing and Healers Among the Northern Cree.* Winnipeg, Manitoba: Natural Resources Institute at The University of Manitoba.

Zimbalist, A.
1992 Teetering on the Brink: Cuba's Current Economic and Political Crisis. *Journal of Latin American Studies* 24: 407-418.

APPENDIX I: Interview Questionnaires

Preguntas Para Las Pacientes

1. ¿Cómo definiría usted la salud?

   ¿Cómo describiría usted la medicina alopatica?

   ¿Cómo describiría usted la medicina tradicional?

   ¿Qué piensa usted de las diferencias principales entre la medicina alopatica y la medicina tradicional en Cuba?

2. ¿Cuáles son los factores principales que influyen en la salud?

   ¿Cuáles diría usted que son sus necesidades en cuidados de salud? (o en lo que a la medicina respecta).

   ¿Qué hace usted cuando se enferma?

   ¿Cuántos veces deciría usted que usted y su familia van al médico?

   ¿Hay algo que usted haga en su casa para prevenir o tratar su salud o la de su familia?

   ¿Cuánto tiempo usted necesita para ver al médico? (o ¿cuánto tiempo le demora a usted ver al médico)?

   ¿Cómo describiría usted su relación con su médico?

   ¿Ha cambiado la forma de cuidar su salud en los últimos diez años (con el comienzo del período especial)? ¿En qué forma?

3. ¿Ha usado usted alguna vez la medicina tradicional? ¿Cuál fue?

   ¿Le han enseñado a usted algo sobre la medicina tradicional? ¿De dónde vino la información?

   ¿Cómo está decidido que forma de medicina usará? (o ¿quién decide que forma de medicina usar)? ¿ (Es una decisión colectiva)?

   ¿Prefiere usted la medicina tradicional o la medicina alopatica? ¿Por qué?

   ¿Cuándo se introduce la medicina tradicional aqui?

¿Por qué piensa usted que Cuba está usando la medicina tradicional ahora?

¿De dónde usted piensa que desciende la medicina tradicional?

¿Cuáles son las ventajas y las desventajas de la utilización de medicina tradicional en Cuba?

¿Cuáles son las ventajas y las desventajas con el sistema de salud publica en Cuba en general?

¿Piensa usted que ahora dispone de más o menos opciones para su salud?

4. En Canáda la medicina tradicional y la medicina alopática se mantienen separadas. Estoy interesante en como es pueden funcionar juntas aqui en Cuba. ¿Podría usted explicarme esto?

5. ¿Cuáles son los retos principales del período especial para la salud y el sistema de salud pública?

   Si el período especial terminará, ¿usted piensa que se seguiría usando la medicina tradicional en Cuba? Por qué?

   ¿Qué piensa usted que es el futuro de la medicina tradicional en Cuba?

   ¿Cómo usted piensa puede mejorarse el sistema de salud publica en Cuba?

6. Conociendo el objectivo principal de mi investigacíon, ¿hay algunas preguntas que usted crea que deba hacer en el futuro?

   ¿Hay algo más que usted quiera añadir?, o ¿algunas otras preguntas que quiera hacerme?

Preguntas Para Los Doctores

1. ¿Cómo definiría usted la salud?

   ¿Cuáles son los factores principales que influyen en la salud?

   ¿Cómo describiría usted la medicina alopatica?

¿Cómo describiría usted la medicina tradicional?

¿Qué piensa usted de las diferencias principales entre la medicina alopatica y la medicina tradicional en Cuba?

2. ¿Usted usa medicina tradicional en su consultorio?

   ¿Dónde y cuándo aprendío usted sobre la medicina tradicional?

   ¿Cómo era lo enseñado a usted? (¿qué manera)?

   ¿Cuándo se introduce la medicina tradicional aqui?

   ¿Por qué piensa usted que Cuba esta usando la medicina tradicional ahora?

   ¿De dónde usted piensa que desciende la medicina tradicional?

3. ¿Cuáles son los retos principales del período especial para la salud y el sistema de salud pública?

4. ¿Piensa usted que la utilización de la medicina tradicional en Cuba es diferente de los otros países? ¿Por qué?

   ¿Cuáles son las ventajas y las desventajas de la utilizacíon de medicina tradicional en su consultorio? ¿Y en Cuba en general?

   ¿Cuáles son las ventajas y las desventajas con el sistema de salud pública en Cuba en general?

   ¿Cómo usted piensa puede mejorarse el sistema de salud pública en Cuba?

5. ¿Cómo esta decidido que forma de medicina usará? (o ¿quién decide que forma de medicina usar)? ¿Escogen los pacientes el tipo de medicina que van a recibir?

   En Canáda la medicina tradicional y la medicina alopática se mantienen separadas. Estoy interesante en como es pueden funcionar juntas aqui en Cuba. ¿Podría usted explicarme esto?

6. ¿Había cambios en la forma de usted practica la medicina durante los últimos diez años? ¿En que forma? (o ¿cómo hecho)?

   En general, ¿cuál es su criterio sobre la opinión que tienen sus pacientes de la medicina tradicional? (o ¿qué piensa usted sobre la opinión de sus pacientes sobre la medicina tradicional)?

   ¿Usted tiene un número determinado de pacientes que tiene que ver?

   ¿Cuántos pacientes ve usted en un día normal?

   ¿Cuánto tiempo emplea usted approximadamente con cada paciente? ¿Usted los sigue viendo?

   ¿Cómo usted describiría su relación con sus pacientes?

7. Si el período especial terminará, ¿usted piensa que se seguiría usando la medicina tradicional en Cuba? ¿Por qué?

   ¿Qué piensa usted que es el futuro de la medicina tradicional en Cuba?

8. Conociendo el objectivo principal de mi investigación, ¿hay algunas preguntas que usted crea que deba hacer en el futuro?

   ¿Hay algo más que usted quiera añadir?, o ¿algunas otras preguntas que quiera hacerme?

Preguntas Para Los Dirigentes

1. ¿Cómo definiría usted la salud?

   ¿Cuáles son los factores principales que influyen en la salud?

   ¿Cómo describiría usted la medicina alopatica?

   ¿Cómo describiría usted la medicina tradicional?

   ¿Qué piensa usted de las diferencias principales entre la medicina alopatica y la medicina tradicional en Cuba?

2. ¿Dónde y cuándo aprendió usted sobre la medicina tradicional? ¿Cómo era lo enseñado a usted? ¿ (qué manera)?

¿Cuándo se introduce la medicina tradicional aqui?

¿Por qué piensa usted que Cuba esta usando la medicina tradicional ahora?

¿De dónde usted piensa que desciende la medicina tradicional?

¿Piensa usted que la utilización de la medicina tradicional en Cuba es diferente de los otros países? ¿Por qué?

3. En Canáda la medicina tradicional y la medicina alopática se mantienen separadas. Estoy interesante en como es pueden funcionar juntas aqui en Cuba. ¿Podría usted explicarme esto?

4. ¿Cómo describiría usted los cambios en la forma de practicar la medicina en Cuba desde que comenzó el período especial?

   ¿Cuáles son las ventajas y las desventajas de la utilización de medicina tradicional en Cuba?

   ¿Cuáles son las ventajas y las desventajas con el sistema de salud pública en Cuba en general?

   ¿Cómo usted piensa puede mejorarse el sistema de salud pública en Cuba?

5. ¿Hay regulaciones para practicar la medicina tradicional en Cuba? Cuáles son?

   ¿Cómo se deciden estas regulaciones? (por ejemplo que formas permiten y que formas no permiten).

6. ¿Cuáles son los retos principales del período especial para la salud y el sistema de salud pública?

   Si el período especial terminará, ¿usted piensa que se seguiría usando la medicina tradicional en Cuba? ¿Por qué?

   ¿Qué piensa usted que es el futuro de la medicina tradicional en Cuba?

7. ¿Conociendo el objectivo principal de mi investigación, hay algunas preguntas que usted crea que deba hacer en el futuro?

   ¿Hay algo más que usted quiera añadir?, o ¿algunas otras preguntas que quiera hacerme?

Preguntas Para Los Profesores

1. ¿Cómo definiría usted la salud?

   ¿Cuáles son los factores principales que influyen en la salud?

   ¿Cómo describiría usted la medicina alopatica?

   ¿Cómo describiría usted la medicina tradicional?

   ¿Qué piensa usted de las diferencias principales entre la medicina alopatica y la medicina tradicional en Cuba?

2. ¿Enseña usted la medicina tradicional?

   ¿Cuándo usted comenzó a enseñarla? ¿Cómo y qué la enseña usted (sobre la medicina tradicional)?

   ¿Dónde y cuándo aprendió usted sobre la medicina tradicional?

   ¿Cómo era lo enseñado a usted? ¿ (qué manera)?

   ¿Cuándo se introduce la medicina tradicional aqui?

   ¿Por qué piensa usted que Cuba está usando la medicina tradicional ahora?

   ¿De dónde usted piensa que desciende la medicina tradicional?

   ¿Piensa usted que la utilización de la medicina tradicional en Cuba es diferente de los otros países? ¿Por qué?

   ¿Cuáles son las ventajas y las desventajas de la utilización de medicina tradicional en Cuba?

   ¿Cuáles son las ventajas y las desventajas con el sistema de salud pública en Cuba en general?

3. En Canáda la medicina tradicional y la medicina alopática se mantienen separadas. Estoy interesante en como es pueden funcionar juntas aqui en Cuba. ¿Podría usted explicarme esto?

   ¿Cuáles son los retos principales del período especial para la salud y el sistema de salud pública?

   ¿Había algún cambio en la forma que usted enseña la medicina en los últimos diez años? ¿Cuáles son?

4. ¿Cómo usted piensa puede mejorarse el sistema de salud pública en Cuba?

   Si el período especial terminará, ¿usted piensa que se seguiría usando la medicina tradicional en Cuba? ¿Por qué?

   ¿Qué piensa usted que es el futuro de la medicina tradicional en Cuba?

5. Conociendo el objectivo principal de mi investigación, ¿hay algunas preguntas que usted crea que deba hacer en el futuro?

   ¿Hay algo más que usted quiera añadir?, o ¿algunas otras preguntas que quiera hacerme?

Preguntas Para Los Santeros/Paleros etc...

1. ¿Cómo forma un Santero/Palero?
2. ¿Cómo definiría usted la salud?
3. ¿Cuáles son los factores principales que influyen en la salud?
4. ¿Usted practica unas formas de ceremonias de la salud? ¿ (podría explicarme)?
5. ¿Usted hace diagnosticas y/o prescribe medicamentos? ¿Qué forma de medicamentos?
6. ¿A veces los doctores envian pacientes a usted? ¿Por qué?
7. ¿Qué es la relación entre la sistema de la salud pública y Santeria?

8. ¿Qué piensa usted sobre la incorporación de la medicina tradicional en la sistema de la salud pública en Cuba? ¿Ha cambiado el numero de pacientes que viene ve a usted o la forma de practicar las cerimonias de la salud?

9. ¿Cuáles son las ventajas y las desventajas de la utilización de medicina tradicional en Cuba?

10. ¿Cómo usted piensa puede mejorarse el sistema de salud pública en Cuba?

11. ¿De dónde usted piensa que la información para la medicina tradicional origina?

12. ¿Por qué usted piensa que algunas personas vienen aqui o a las tiendas yerbas en vez de una farmacia?

APPENDIX II: Homeopathic Medications Prescribed

List of Homeopathic Remedies I saw prescribed, and what Anna told me they are good for:

It is important to note that Anna also told me that all homeopathic remedies are prescribed based on the person's constitutional make-up. This is why a "homeopathic interview" was usually done with new patients of homeopathy. The interview would take anywhere from 20 minutes to almost two hours; and many questions were asked about the patient's likes and dislikes, constitutional makeup, medical history, and personal and family situation. Anna also told me that sometimes homeopathic medicines could be used to treat a particular ailment, but that this is not the way in which homeopathy was intended to be used.

Name of Medication	**Use**
Aconitum	Viral problems
Apis	Insect bites, allergies, inflammation (red skin and throat and articulations), menstrual inflammation.
Alumina	Constipation.
Arnica	Traumas - bruising and pain in the muscles.
Arsenica (sometimes prescribed arsenica album)	Diarrhea; people who are very meticulous. It is best for people who have asthma at night, stomach problems (especially diarrhea which is acidic), burnt skin.
Baryta Carbonica	Forgetfullness and concentration problems, for children who are slow and seniors who forget.
Belladonna	Flu with headache and pain in the throat; hypertension. You know when to prescribe this because they have a hot head and face and their eyes are red.
Bryonia	Strong pain (especially when moving); flu with a high fever and headache.
Calcarea carbonica	People who are scared of everything; obese, pale, and weak; good for chronic cases; underdeveloped bones and teeth; memory problems; slow people.
Calcarea phosphorica	Good for teeth; reforming of the bones; broken bones; pain in the bones.

Cantharis	Urinary problems; cystitis
Causticum	Flus and diarrhea; acute problems; "se fue la voy"
Cina	Intestinal parasites; blood as well but mostly parasites.
Coffea	Insomnia
Dulcamara	Respiratory problems and articulation problems that come with a lot of humidity and when the temperature changes.
Euphrasia	Respiratory and dermatological problems. For people who are better when they are close to the ocean.
Gelsemium	Suffering from anticipation; very nervous which causes vomiting; flu; people with a lot of stress
Giardinum	Tropical parasites
Glonoinum	Heart problems; hypertension
Graphite	Skin problems; psoriasis; dry lesions on the skin; frost bite and runny nose
Hepar sulphur	This is an antibiotic, it is the biggest of all. For things with a lot of pus.
Hypericum	Nerve calmer; anaesthetic. You can put it under your tongue to use as an anaesthetic at the dentist.
Ignatia	Sentimental depression; very sad and cry a lot; breathe deep sighs because depressed; hysterical people who cry and scream.
Lachesis	Bad people; classic "mala suegra"; very jealous; menopause.
Ledum palustre	Lesions from cuts or bites; problems in the articulations.
Licopodium	Memory and concentration; hypertension; digestive problems; asthma; psoriasis; impotence in men.
Natrum muriaticum	
Nictinum	To quit smoking - only for addiction to cigarettes
Nux vomica	This is a big one. Anti-histamine for allergies; digestive problems; diarrhea; vomiting (lots of allopathic treatments); asthma; hypertention from food.

Phosphorus	Blood problems; fear; chronic flu or cold; menstruation problems; anti-coagulate before an operation; very good for bronchitis and asthma and respiratory problems.
Pulsatilla	White vaginal secretions; depression with a lot of crying; people who cry a lot and feel a lot of frustration over love and work; low self-esteem, very dependent; mood swings with menstruation. Pain that changes location and personalities that cry a lot.
Rhus tox	Arthritis and arthrosis; pain in the articulations. In the morning you cannot walk or after sitting for a long time; skin and chickenpox.
Ruta	Ligaments; tendinitis.
Sepia	This is a big one for women. Very sentimental; sexual problems; hot menstruation; marks on face from being pregnant; yellow and bad smelling discharge; hypertension, sad and very depressed (deprimidos) after 45 years of age.
Silica	Antibiotic for infections in the bones (fractures in the bones?); ingrown nails, sweaty hands and feet from being shy.
Staphysagria	Menopause; nerves; very aggressive; bad character; "piojo"
Sulphur	This is the biggest one of all _ it serves for all. Ten days of sulphur is given if it is unclear what is wrong with the patient; and then after the ten days it is clear what the patient has. Good for lesions of the skin; chronic illnesses; forgetfulness and children who cannot concentrate.
Tabacum	To quit smoking; dizziness.